LEGISLATIVE HEARING ON: DRAFT LEGISLATION TO IMPROVE REPRODUCTIVE TREATMENT PROVIDED TO CERTAIN DISABLED VETERANS; DRAFT LEGISLATION TO DIRECT THE DEPARTMENT OF VETERANS AFFAIRS (VA) TO SUBMIT AN ANNUAL REPORT ON THE VETERANS HEALTH ADMINISTRATION; H.R. 271; H.R. 627; H.R. 1369; H.R. 1575; AND, H.R. 1769

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Thursday, April 23, 2015

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Thursday, April 23, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Bilirakis, Roe, Huelskamp, Coffman, Wenstrup, Abraham, Brownley, Takano, Ruiz, Kuster, and O'Rourke.

Also present: Representatives Walorski and Titus.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. The subcommittee will come to order.

Before we begin, I would like to ask unanimous consent for my friends, colleagues, and members of the full committee, Congresswoman Jackie Walorski of Indiana and Congresswoman Dina Titus of Nevada, to sit on the dais and participate in today's proceedings. Without objection, so ordered.

Thank you all for joining us today as we discuss seven bills that will impact the healthcare provided to our Nation's veterans by the Department of Veterans Affairs' healthcare system.

The bills on our agenda today are draft legislation to improve reproductive treatment provided to certain disabled veterans; draft legislation to direct VA to submit to an annual report on the Veterans Health Administration; H.R. 271, the Creating Options for Veterans Expedited Recovery or COVER Act; H.R. 627 to expand the definition of homeless veteran for purposes of benefits under the laws administered by VA; H.R. 1369, the Veterans Access to Extended Care Act of 2015; H.R. 1575 to make permanent the pilot program on counseling in retreat settings for women veterans

newly separated from service; and, H.R. 1769, the Toxic Exposure Research Act of 2015.

I am proud to sponsor two of the bills on our agenda, the draft bill to direct VA to submit an annual report on the Veterans Health Administration and H.R. 1769, the Toxic Exposure Research Act of 2015.

The draft bill would require the VA to submit an annual report to Congress regarding the provision of hospital care, medical services, and nursing home care by the VA healthcare system. The annual report would contain information regarding access to care, quality of care, workload, patient demographics and utilization, physician compensation and productivity, purchased care, and pharmaceutical prices.

This measure is the result of the subcommittee's oversight hearing in January where the Congressional Budget Office testified that VA provided limited data to Congress and the public about its costs and operational performance and that if it was provided on a regular and systemic basis could help inform policymakers about the efficiency and cost effectiveness of VA's services.

Similar sentiments were echoed by witnesses from The American Legion and the Independent Budget. VA must become more transparent and forthcoming about the care that it provides to our Nation's veterans so that Congress, stakeholders, taxpayers, and veterans can make informed determinations about the services that the department is offering and how they can be improved.

The intent of our hearing in January was to determine the cost and value of VA care. But during our discussion, it became painfully obvious that the department leaders were unable to provide basic information about, say, how much the VA spends on a single patient encounter in a VA primary care clinic.

As a doctor myself, it is unfathomable to me that the VA either does not have or is unwilling to share granular data about the cost of the services it provides. This bill and the free flow of information that it will require of the VA on a yearly basis will fix that once and for all, resulting in a better, stronger VA healthcare system that our veterans deserve.

My other bill, the Toxic Exposure Research Act of 2015, would establish a national center for research into the health conditions experienced by the descendants of veterans exposed to toxic substances. It would also create an advisory board who would be responsible for advising the national center, determining health conditions that result from toxic exposure, and studying and evaluating the cases of exposure.

In addition, it would authorize the Department of Defense to declassify documents related to a known incident in which at least a hundred servicemembers were exposed to a toxic substance that resulted in at least one case of related disability.

Finally, it would create a national outreach campaign jointly led by VA, DoD, and the Department of Health and Human Services on the potential long-term health effects of exposure to toxic substances by servicemembers, veterans, and their descendants.

As I said before, injuries or illnesses that result from exposure to toxic chemicals can have life-long and generational effects, the impacts of which we do not yet fully understand, but are neverthe-

less painfully prevalent to the veterans and family members who experience them.

For them and for future generations, we must do more to recognize, research, and treat toxic exposure issues and thoroughly evaluate the long-term effects exposure can have not just on those who serve but on their children and grandchildren as well.

Mr. BENISHEK. Enough about my bills. In addition to those bills, I am proud to be an original cosponsor for H.R. 627 which would expand the definition of a homeless veteran to include veterans and their families who are fleeing from domestic or dating violence, sexual assault, stalking or other life-threatening conditions in their current home and lack the resources to obtain other permanent housing.

Veterans who are living in a violent home deserve our support as they recover from the devastating effects of intimate partner violence and begin to reclaim their lives.

I am grateful to my friend and colleague, Congresswoman Janice Hahn from California, for championing their cause with this legislation and I urge all my colleagues to join us in cosponsoring H.R. 627.

The draft bill 1769, H.R. 1769 and H.R. 627 are supported by a number of our veteran service organizations and I thank them all for their support and comments and recommendations. I look forward to working closely with them, the department, and other stakeholders beginning with today's hearing to strengthen these and all the bills on our agenda where needed and advance them through the subcommittee without delay.

I thank all of our witnesses and the audience members for being here today and I will now yield to the Ranking Member Brownley for any opening statements she may have.

OPENING STATEMENT OF RANKING MEMBER JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chairman, for calling this hearing this morning.

I don't have any bills to speak to today personally, but I do look forward to hearing from members and witnesses today regarding the five bills and two pieces of draft legislation that are on the agenda this morning including yours, Mr. Chairman.

As we deliberate on the multitude of issues and concerns that are before us each and every Congress, it is critical that we are as informed as we possibly can be on all of the issues. We rely on the information we receive during these legislative hearings to improve upon the services and benefits that the Department of Veterans Affairs provides to our veterans and their families. It is also important that we are made aware of any unintended consequences that may arise from these different bills.

Today we will hear, as the chair has already stated, we will hear from the panels on a variety of bills concerning the subcommittee's jurisdiction. We have two bills addressing the treatment of mental health, one on domestic violence and on homeless veterans, one on research and to toxic exposures, and a bill that addresses the provision of extended care services to veterans.

In addition to the five bills, we will hear about two pieces of draft legislation. The first would authorize VA to provide in vitro fertilization services to eligible veterans and spouses. The second requires the VA to submit a report to Congress on hospital care, medical services, and nursing homes.

I am on the record as a supporter of reproductive rights for all our veterans. Too many of our young men and women have been injured so severely that having children is now not an option. IVF might not be the solution for these families and we need to be sensitive to their needs also.

Hopefully we can work together to find a way forward to ensure that all veterans who want a family including same sex veterans will have all the support and assistance they may need to do that.

I appreciate all the witnesses being here today. I appreciate the chair calling this meeting and I look forward to everyone's testimony. I yield back.

Mr. BENISHEK. Thank you.

Well, we are this morning to be joined by several other of our members who are sponsoring legislation this morning. Mr. Miller, the chairman of the committee, will be in, Congressman Gus Bilirakis from the 12th District of Florida, Congresswoman Janice Hahn from the 44th District of California, Congresswoman Jackie Walorski from the 2nd District of Indiana.

I think I will start with Mr. Bilirakis. Would you please go ahead with your legislation.

STATEMENT OF HON. GUS BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. BILIRAKIS. Mr. Chairman, I appreciate it very much and I want to thank the ranking member as well.

Thank you for holding this very important hearing and giving me the opportunity to discuss my bill, H.R. 271, the Creating Options for Veterans Expedited Recovery Act, the COVER Act.

Statistics show that one in five veterans who serve in Iraq and Afghanistan have been diagnosed with the posttraumatic stress. Now, we must responsibly ask ourselves are we doing enough when it comes to addressing mental health in our veterans' population. I don't think so.

Recent data has shown that every day in this country, approximately 18 to 22 veterans take their own lives. This statistic answers the question I posed earlier. It is obviously more—Mr. Chairman, more needs to be done in my opinion. That is why I introduced the COVER Act in the 114th Congress.

The COVER Act will establish a commission to examine the Department of Veterans Affairs' current evidence-based therapy treatment model for treating mental illness among veterans. It will also analyze the potential benefits of incorporating complementary, alternative treatments available within our communities.

The duties of the commission designated under the COVER Act include conducting a patient-centered survey within each Veteran Integrated Service Network. The survey will examine several different factors related to the preferences and experiences of veterans when they have dealt with the Department of Veterans Affairs.

Instead of presuming to know what is best for veterans, we should just ask the veteran. It is as simple as that. Then we can work with veterans on finding the right solution that best fits their own unique needs. Not one size fits all.

The scope of the survey will include the experience of a veteran when seeking medical assistance within the Department of Veterans Affairs, the experience of veterans with the non-VA medical facilities and health professionals for treating mental health illness, the preferences of a veteran on available treatments for mental health and which they believe to be most effective, the prevalence of prescribing prescription drugs within the VA as remedies for treating mental illnesses, and outreach efforts by the VA secretary on available benefits and treatments.

Additionally, the commission will be tasked with examining the available resources on complementary, alterative treatments for mental health. Then the commission will identify what benefits could be attained with the inclusion of such treatments for our veterans seeking care at the VA.

Some of the alternative therapies include among others, of course, accelerated resolution therapy, music therapy, yoga, acupuncture therapy, meditation, outdoor sports therapy, and training and care for service dogs.

Finally, the commission will study the potential increase in health claims for mental health issues for veterans returning from the most recent theaters of war. We must ensure that the VA is prepared with the necessary resources and infrastructure to handle the increase in those utilizing their earned benefits to address the mental and physical elements incurred from military service.

Once the commission has successfully completed their duties, a final report will be issued. Its recommendations and findings will be made available based on the analysis of the patient-centered survey, alternative treatments, and evidence-based therapies.

The commission will also be responsible for creating a plan to implement those findings in a feasible, timely, and cost-effective manner.

Last Congress, I was very pleased that the subcommittee considered the COVER Act in a legislative hearing. At this hearing, all the VSOs and organizations testified and have supported the COVER Act. I want to thank all again, all of you really for your support through your testimonies given today.

In this year's draft, I was also pleased to incorporate the recommendations offered by the Vietnam Veterans of America. They suggested that appointees on the commission must not have proprietary, financial, or any other conflicting interest in any of the treatment considered, and I think that is very reasonable and I appreciate their recommendations.

In closing, we have the support from veterans and the organizations that work closely with them. And it is clear that there is a need to do more and that is what we need to do. We need to do more for our true American heroes. We have that responsibility. We have that duty.

The question now is this: What do we intend to do about it? We definitely have to act on this bill and I really appreciate, Mr.

Chairman, you agendaing this bill today and I would love to see it marked up very soon.

With that, I urge my colleagues again to support this bill and cosponsor this bill. Let's get this done for our heroes. Thank you.

[The prepared statement of Gus Bilirakis appears in the Appendix]

Mr. BENISHEK. Thanks, Mr. Bilirakis.

Now we will hear from our colleague, Representative Hahn. You are now recognized for five minutes.

STATEMENT OF HON. JANICE HAHN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. HAHN. Thank you. And thank you, Chairman Benishek, for holding this hearing. It is an honor for me to be with Ranking Member Brownley and really all the distinguished members of this committee. Thank you.

Homeless veterans are such a pressing problem for this Nation. More than 62,000 veterans are homeless on any given night and over 120,000 veterans will experience homelessness over the course of the year. And while only seven percent of Americans qualify as veterans, they make up nearly 13 percent of the homelessness population in this country. Sadly, my hometown, Los Angeles County, has the most homeless veterans in the Nation.

And today I wanted to address one segment of homeless veterans, those who are homeless because of domestic violence. Currently the Department of Veterans Affairs' definition of homeless veterans does not include veterans who are homeless because of domestic violence. And across the country, we know too many victims of domestic violence feel there is nowhere for them to turn.

And lacking resources, help, and a safe place to go, many of these victims feel like their only choice is to remain with their abusers. And tragically too often women veterans are among those who find themselves in this horrible situation.

According to the VA, 39 percent of our women veterans report experiencing domestic violence. That is well above the national average. And, however, because of antiquated laws on the books, they have not been eligible to access resources designated for homeless veterans.

I approached Chairman Benishek with my legislation, H.R. 627, which updates the definition of homeless veteran to include victims fleeing domestic violence. And not only was he extremely supportive, but he joined me in introducing it. And for that, I really thank you, Chairman.

Our legislation will update the definition of homeless veteran to include veterans fleeing domestic violence and will correct what I believe is an oversight and ensure that veterans fleeing domestic violence can receive benefits from the VA. This is a minor change, but it has great importance to ensure that our veterans do not feel trapped in dangerous situations.

H.R. 627 is endorsed by countless veterans' organizations such as the Veterans of Foreign Wars, AMVETS, the National Coalition for Homeless Veterans, the Servicewomen's Action Network, Blinded Veterans Association, and we have many more on that list.

Providing benefits to veterans driven to homelessness by domestic violence is, I think, something we should all support and we have supported that in the past. In fact, I have worked with House Appropriations Veterans Affairs' subcommittee to include report language the past two years to make these benefits available.

But that process only helps until the next year and has to be repeated every year to provide this temporary help. I think it is time to stop making temporary fixes. This legislation permanently fixes this loophole for veterans. And while it is unknown how many veterans will be helped by this bill, I just believe if it helps one veteran get the support they need and to leave a dangerous situation, then our work here will be worth every minute. Let's step up to provide these heroes who have protected us with the resources they need including a place where they can be safe and protected.

In conclusion, I want to thank you for working with me to solve an urgent problem and I yield back the balance of my time.

[The prepared statement of Janice Hahn appears in the Appendix]

Mr. BENISHEK. Thank you very much.

Representative Walorski, you are recognized for five minutes.

STATEMENT OF HON. JACKIE WALORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Ms. WALORSKI. Good morning. Thank you.

Chairman Benishek, Ranking Member Brownley, members of the committee, thank you for the opportunity to discuss H.R. 1369, the Veterans Access to Extended Care Act. This important bill would expand veterans' access to certain healthcare services and allow former servicemembers to receive those services from local providers.

Currently VA offers a variety of long-term services and support to veterans including nursing home care, adult day care, respite care. Non-VA providers at community organizations must contract with the VA under the Service Contract Act to provide these services.

The Service Contract Act's burdensome reporting requirements, the Department of Labor, along with the compliance costs discourage local providers from entering into contracts with the VA. This situation has left many veterans and their families without the ability to find providers close to home.

In February of 2013, the VA issued a proposed rule which would have allowed providers to enter into these agreements with the VA under the same guidelines that providers for Medicare enter into agreements with CMS. Non-VA providers would no longer be considered federal contractors, relieving them from the burdensome reporting requirements.

In conjunction with a Senate letter that was sent June of 2014, Congresswoman Tulsi Gabbard and I along with 107 of our colleagues in the House sent a letter in August of 2014 to Secretary McDonald encouraging the release of the final VA provider agreement rule. Unfortunately, despite the willingness of the department, the VA never had the legislative authority to begin to enact the rule.

In response, Representative Gabbard and I introduced H.R. 1369, Veterans Access to Extended Care Act. This commonsense bill gives the VA the legislative authority, the fix it needs to follow through the original proposed rule. Specifically this bill exempts extended care service providers from being treated as federal contractors for the acquisition of goods or services.

The bill also relieves providers from certain reporting requirements to the Department of Labor. Lastly, it includes quality assurance provisions to ensure the safety and a high standard of care our veterans deserve.

Incentivizing more local providers to work with the VA will increase access to care that is closer to home, allowing family and friends to provide additional support structures to our veterans. The family structure during these times is vital to ensuring a veteran's quality of life.

These individuals have sacrificed so much in the name of liberty, they should not have to worry about being able to find care close to home because their hometown providers don't have the necessary resources to qualify as a government contractor. Eliminating this designation will encourage more extended service providers to enter into agreements which will provide much more options, many more options to our veterans.

Providing veterans with the care they need and deserve continues to be a top priority of mine and most of us on this committee. I am grateful to work with Representative Gabbard, Senator Hoeven, Senator Manchin, and the committee in addressing this critical issue for our veterans.

And I thank you again, Mr. Chairman, Ranking Member Brownley, for the opportunity to be here today. I yield back my time.

[The prepared statement of Jackie Walorski appears in the Appendix]

Mr. BENISHEK. Thank you very much for your testimony.

The chairman of the committee is expected to be here to testify on behalf of his legislation as well, but I am not going to ask any questions of the members here in the reference of time because I know I am going to have adequate time to talk to them as time goes by here in the House.

Ms. Brownley, do you have any questions?

Any questions for the panel members from any of the members?

And thank you. The first panel is excused. And then we will proceed with the second panel.

Mr. TAKANO. Dr. Benishek, just a real quick question of Mr. Bilirakis and Mr. Ruiz, Dr. Ruiz.

Your commission that you are trying to set up is a very interesting one to me and I commend you for the bill. And I gather the big impetus is to try and find ways to not necessarily—I mean, former Secretary Shinseki I remember talking about the use of medications and how we are using too much of them with our veterans.

I want to share with you that I was at an event probably last session with a California Commission for the Humanities and Professor Emeritus David Glidden of University of California Riverside is a professor of philosophy. And one of the participants was a fe-

male veteran who had taken part in his philosophy class which explored the big moral questions about life, you know.

And it strikes me that a lot of veterans face not just the mental issue, mental health issues but the spiritual issues. We send young people into battle, many of them not really thinking about the moral consequences of war, and they come back with all that weighing on their minds. And rather than medications, many of them just really could benefit by going to a well-considered course put together by a very talented person in humanities.

And I wonder if you might consider looking at including a perspective, say, from the National Endowment for the Arts or the National Endowment for the Humanities ways to leverage those budgets and encouraging our humanities and arts community to think about how they can engage with our veterans. And this is also providing a pathway that is different than medication.

And one of the things that this veteran mentioned was that sometimes there is a stigma attached to seeking mental health and this is another pathway that a veteran can take that, you know, doesn't necessarily mean that they have to feel like they are stigmatized by that.

And, of course, we want to remove the stigma period.

Mr. BILIRAKIS. Absolutely.

Mr. TAKANO. But it is a thought I wanted to offer.

Mr. BILIRAKIS. Oh, I would be willing to discuss that with you.

Mr. TAKANO. Yes. Thank you.

Mr. BILIRAKIS. Again, you know, the examples that I used are just examples and we are not limiting it to that. And I would like to hear maybe from Dr. Ruiz, too, because he is a cosponsor of my bill, the prime cosponsor. But I would take that into consideration. I would be happy to discuss that with you.

Mr. RUIZ. Thank you. I think that the commission will be looking at events like that and that is why want to form the commission——

Mr. BILIRAKIS. Absolutely.

Mr. RUIZ [continuing]. Because then they can look at what the state-of-the-art mental health counseling and therapy exist out there and start to incorporate those for our veterans. And I think it will be helpful.

Mr. TAKANO. Yes. With all respect to the medical background, and I don't want to diminish any—we don't want to diminish the role of medication or therapy, but thinking of also the nonmedical ways of also treating folks even with the existing budgets or even a tiny bit of leverage from Federal Government to try these other—so I was hoping that you would look at representing on the commission folks within the humanities and the arts as well.

Mr. COFFMAN. Mr. Chairman.

Mr. BENISHEK. Yes.

Mr. COFFMAN. Mr. Bilirakis, one thing I would like the—my concern as a combat veteran is that the largest cost driver I think probably in VA healthcare is posttraumatic stress disorder in terms of disability payments.

In talking to professionals in psychiatry and psychology and the different therapists seem to think that with the proper treatment that the stress disorders from being in a combat zone could be

brought down to a level where it is no—that those stressors are no longer debilitating, yet one of the considerations I think your commission should look at is should there be a requirement or what can we do to encourage those who are on disability for posttraumatic stress disorder to receive treatment because I think it is a disservice to those veterans and it is, quite frankly, as a taxpayer, it is a disservice to the taxpayers of this country.

We have got to figure out how to help people. We have got two different definitions. The Department of Defense sees posttraumatic stress as a wound and the Veterans Administration sees it as a disability. I think we have got to link those two up. As a combat veteran, I see it as a wound and wounds are treatable. Some may not be.

But the system makes no effort or little effort and so I think that it ought to be a factor to say what can we do to restructure the system going forward, or does it need to be restructured going forward, I don't know, that creates a mechanism whereby people are encouraged or required to participate in treatment.

Mr. BILIRAKIS. That is definitely worthy of a discussion. And, again, the idea behind this bill is we need to give the veteran the choice because not one size fits all with regard to the therapy. So I will take all these matters under consideration, but we got to pass the bill first. Thank you.

Mr. BENISHEK. Mr. Ruiz, Do you have a comment?

Mr. RUIZ. Yeah. I would like to make a statement regarding this bill and applaud Mr. Bilirakis for the work that you are doing for our veterans in improving their mental health services.

So I would like to thank Mr. Chairman and Ms. Ranking Member and thank also the panelists that we are going to hear from today, the veteran service organizations for joining us. The VA's mission is to care for those that, quote, "shall have borne the battle." And the most essential part of that task is to heal our wounded warriors, our wounded veterans. However, more and more our soldiers are returning with psychological wounds, illnesses that do not present as obviously as physical maladies but are just as damaging.

That is why I am an original cosponsor of H.R. 271, the COVER Act, which I am glad to see included in today's hearing. This bill will ensure that no stone is left unturned in exploring ways to provide timely, effective, veteran-centered mental healthcare for those who have served in our Armed Forces.

I am proud to have worked with outstanding veteran service organizations and the veterans in my district to ensure that the VA listens to the foremost experts on what veterans need, the veterans themselves.

In that same spirit, this bill will help give veterans a voice in their treatment by requiring a comprehensive survey of veterans' experiences and preferences. To achieve real progress towards improving mental healthcare in the VA, we must incorporate veterans' recommendations.

As a physician who has treated the whole range of patients that come into the emergency department, I know that one-size-fits-all approach doesn't work for veterans with mental health needs. This bill will help give our veterans mental healthcare options that work

for them and will lay the groundwork for future solutions that are the product of listening to our veteran community.

I look forward to working with Vice Chairman Bilirakis and other members of this committee to create an inclusive process where veterans' voices and views are heard and I urge my colleagues to support this bill.

Thank you and I yield back.

Mr. BENISHEK. All right. Thanks.

Does anyone else have any questions or comments?

Mr. ROE. Just very briefly I guess to just second what two of my colleagues have said.

One, Mr. Coffman, I think you are absolutely right on. We should stop calling this posttraumatic stress disorder and posttraumatic stress and look at how we heal these veterans and get them back into the workforce and have productive lives, not to say that I have this condition.

If you have been in war, I have said this many times here, and somebody shoots at you, that is going to make you anxious. There would be something wrong with you if you didn't. And you are going to—I mean, I would think there would be something really wrong if you didn't get scared if somebody shot at you.

And I think the goal ought to be with the commission is how do we, and I think this is a, Mr. Bilirakis, a tremendous idea that you all have come up with, to finally get in one arena a group of people, experts to put together some ideas about how we do what you are saying, about how we get these folks who are on disability, get them back in the workforce and get them back at productive lives. I think that is something we absolutely have to do.

And, Mr. Takano, I could not agree more with you in including some alternative things like the arts, music. I can tell you it is very beneficial for people and can be very healing to people. And having used that myself, I know it works. And so I think it is a phenomenal idea.

I am very supportive and I think we need to expand, Mr. Bilirakis, what you are doing and with all these ideas that have come in. I think this it is a wonderful idea.

And with that, I yield back.

Mr. BENISHEK. Great. Okay. Ms. Kuster, Do you have a question as well?

Ms. KUSTER. Just a quick comment. I wanted to thank you, the chair. I have been an adoption attorney for 25 years and worked with a lot of people in the area of reproductive health and just wanted to say I support the effort in your bill. And I think it is an important point.

And then I think Representative Walorski is gone, but I just wanted to thank her for her efforts and also Representative Hahn, the bill about women and her homelessness issue, about domestic violence and women trying to seek shelter and safety.

So I just want to commend the chair and the panel for some great legislation and look forward to working with you all.

Mr. BENISHEK. Well, thanks.

Ms. KUSTER. Thank you.

Mr. BENISHEK. Appreciate that.

Mr. Miller has arrived, so he wants to present his legislation as well. Mr. Miller, you are recognized.

Mr. MILLER. Thank you very much, Mr. Chairman, to the ranking member. And I apologize for being late this morning, but it is always good to be in the Subcommittee on Health. I appreciate all the members' attention and your diligence at the full committee level and certainly with what is going on here today.

I want to talk with you about issues as it relates to reproductive treatment that is provided to certain disabled veterans. Now, currently the conflicts in Iraq and Afghanistan over the last decade have resulted in significant increases in reproductive organ and spinal cord injuries among our servicemembers. These wounds can have serious and life-long repercussions on the daily lives of our veterans and their families, not the least of which can be the inability to conceive a child.

While the Department of Veterans Affairs does provide a number of fertility services to veterans, VA is currently prohibited via regulation from providing in vitro fertilization, one of the most well-known and arguably most effective assisted reproductive technologies. The VA is prohibited also by statute from providing any such treatment to a veteran's spouse.

In contrast, the Department of Defense has been providing IVF to severely-wounded servicemembers since 2010. What this disparity results in is having severely-disabled veterans having to decide whether or not to pursue a family through IVF before they separate from the service while still actively recovering from their wounds and during what can be a highly stressful transition period or pay for the procedure out of pocket once they move to veteran status.

Because IVF can be costly, for some veterans waiting until they are in VA care can mean having to choose between a financial free-fall or foregoing their dreams of having a child altogether. This is an agonizing and unacceptable choice that this draft bill would help prevent veterans with these disabilities from ever having to make.

The draft bill would authorize VA to provide assisted reproductive technology in addition to any fertility treatment already authorized to enroll veterans whose service-connected disability includes an injury to the reproductive organs or spinal cord that directly results in the inability to procreate without the use of assisted reproductive technology.

Assisted reproductive technology is defined in the bill to include IVF as well as other technologies determined by VA as appropriate to be used to assist reproduction. In furnishing IVF or similar procedures to an eligible veteran, VA would also be authorized to provide services to that veteran's spouse. Like DoD, VA would be limited to providing eligible veterans three in vitro fertilization cycles resulting in a total of not more than six implantation events.

The draft bill would further stipulate that VA is authorized to provide for storage of genetic material for three years after which the veteran and his or her spouse is responsible for the cost of such storage, that VA cannot process or make any determinations regarding the disposition of genetic material, and that VA is required

to carry out activities relating to the custody or disposition of genetic material in accordance with the relevant state law.

Finally, the draft bill would prohibit VA from providing any benefits relating to surrogacy or third-party genetic material donation. So in short, this legislation mirrors the IVF benefit that is provided to active-duty servicemembers in DoD, creating parity between the two departments while opening the door for parenthood for disabled veterans who may otherwise not have the resources to pursue such a path.

And I am proud to say that this proposal is supported many of our VSOs, by resolve the National Infertility Association and by the American Society for Reproductive Medicine. And I want to thank all of them for their support, for this draft, and for their thoughtful comments and recommendations for how it could be improved.

I look forward to working hand in hand with each of you subcommittee members to address those suggestions and otherwise strengthen the language in the draft bill before it is introduced and moved forward. This draft is derived partly from the recent subcommittee roundtable wherein fertility among disabled veterans was discussed in depth. And I am grateful to you, Dan, for holding the roundtable as well as this hearing today. And I urge my colleagues support this draft bill and I yield back. Thank you for your time.

Mr. BENISHEK. Thank you very much, Mr. Chairman.

Any other comments for the chairman?

Mr. Roe.

Mr. ROE. Just very briefly some history. In vitro fertilization came along in my career as an obstetrician/gynecologist. Dr. Patrick Steptoe in England did a hundred laparoscopic in vitro implantations before he had one success. Egg gatherings, he did a hundred. It is now standard medical therapy.

And I wholeheartedly support this legislation. It is past due. We should do this for our very, very seriously-wounded veterans who want to have families. I can't think of anything more honorable to do than this.

I yield back.

Mr. BENISHEK. Thank you.

I think with that, we will ask the second panel to take the stage here. Joining us on the second panel is Blake Ortner, the Deputy Government Relations Director for the Paralyzed Veterans of America; Louis Celli, Jr., the Director of the National Veterans Affairs and Rehabilitation Division for The American Legion; John Rowan, the National President of the Vietnam Veterans of America; and Adrian Atizado, the Assistant National Legislative Director for the Disabled American Veterans.

Thank you all for being here and for your hard work and advocacy on behalf of our veterans. I appreciate you being here to present your views of your members.

And I think we will begin with Mr. Ortner. Mr. Ortner, you are recognized for five minutes.

STATEMENTS OF BLAKE ORTNER, DEPUTY GOVERNMENT RELATIONS DIRECTOR, PARALYZED VETERAN OF AMERICA; LOUIS J. CELLI JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION; JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA; ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF BLAKE ORTNER

Mr. ORTNER. Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America would like to thank you for the opportunity to present our views on legislation before the subcommittee.

PVA supports the draft legislation to provide assisted reproductive technology or ART such as in vitro fertilization to certain disabled veterans. For many disabled veterans, one of the most devastating results of spinal cord injury or dysfunction is the loss of or compromised ability to have a child.

While the Department of Defense does provide ART to servicemembers and retired servicemembers, VA does not. When a veteran has a loss of reproductive ability due to a service-connected injury, they must bear the total cost for any medical services should they attempt to have children. Procreative services provided through VA would ensure that disabled veterans are able to have a full quality of life that would otherwise be denied them due to their service.

The bill also offers veterans the option of cryopreservation of genetic material for three years to protect their viability to have a family in the event medical treatments or medications affect the quality of their genetic materials.

While PVA strongly supports this draft legislation, it is limited in addressing the needs of women veterans. Some women veterans with a catastrophic injury may be able to conceive through IVF but be unable to carry a pregnancy to term due to their disability. In such an instance, implantation of a surrogate may be their only option.

The current draft of the bill is not inclusive of all women veterans with a catastrophic reproductive injury and we believe clarification is necessary where the draft prohibits any benefits relating to surrogacy or third-party genetic material donation.

PVA generally supports draft legislation to require a yearly evaluation of overall effectiveness of the Veterans Health Administration in improving access to care and the quality of it. In order to improve this bill, PVA strongly encourages adding language to reinstate the reporting requirement that expired in 2008 on the capacity of VHA to provide specialized services to disabled veterans.

The VA has not maintained its capacity to provide for the unique healthcare needs of severely-disabled veterans, veterans with spinal cord injury or disease, blindness, amputations, and mental illness.

Currently within the SCI system of care, VA not meeting capacity requirements for staffing or number of inpatient beds is consistently reported throughout the system. VA has eliminated staffing

positions or operated with vacant healthcare positions for prolonged periods of time. When this occurs, veterans' access to VA decreases, remaining staff become overwhelmed with increased responsibilities, and the overall quality of healthcare is compromised.

As a component of its workplace planning, VA tracks this information and is able to compile and use the collected data for annual reports, so this should not be an undue burden.

PVA understands the intent of and generally supports the Toxic Exposure Research Act of 2015. However, the bill does not discuss the processes should the advisory board conflict with the findings of IOM. We encourage the subcommittee and VA to work together to ensure legislation fulfills the IOM Committee recommendations.

PVA supports H.R. 271, the Creating Options for Veterans Expedited Recovery Act. PVA believes that effective medical care, traditional or alternative, ought to be readily available to a veteran in need and that all VA mental healthcare should meet the specific individual need of the veteran on a consistent basis.

Complementary and alternative medicines give veterans with mental illness as well as catastrophic disabilities additional treatment options and the commission could offer an opportunity to identify additional best practices across medical disciplines.

PVA supports H.R. 627 to expand the VA's definition of homeless to match the definition used by the Department of Housing and Urban Development since 1987. Domestic violence is just as much a public health matter as homelessness and for women veterans, it is a major cause. Thirty-nine percent of women veterans report experiencing domestic violence, well above the national average.

As a result of definitions outlined in Title 38, these veterans are not eligible to access resources for homeless veterans.

PVA generally supports H.R. 1369, the Veterans Access to Extended Care Act of 2015, which would allow veterans to obtain non-VA long-term services and supports from local providers. The bill would also allow LTSS providers to enter the VA provider agreement rather than contracting with VA, thereby avoiding the complex processes required under the Service Contract Act.

Finally, PVA supports H.R. 1575, a bill to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces. The bill would provide VA with the authority to extend the program using the same measurements and eligibility requirements. It is essential that Congress reauthorize this program as we believe the value and efficacy is undeniable.

Mr. Chairman, PVA thanks the subcommittee for the opportunity to submit our views and I would be happy to answer any questions.

[The prepared statement of Blake Ortner appears in the Appendix]

Mr. BENISHEK. Thank you very much for your testimony, Mr. Ortner.

Mr. Celli, you may begin your statement, five minutes.

STATEMENT OF LOUIS J. CELLI, JR.

Mr. CELLI. I can't remember a hearing in recent history where The American Legion completely supported and stood behind every bill being offered for consideration. What this demonstrates is an

overwhelming bipartisan partnership with veteran service organizations and with veterans to ensure the Congress gets it right.

On behalf of our National Commander Mike Helm and the millions of veterans that make up The American Legion, thank you. Good job.

The World Health Organization defines reproductive health as a state of complete physical, mental, and social well-being at all ages and stages of life and not merely the absence of reproductive disease or infirmity. According to a study of veterans who served during OIF and OEF, 15 percent of women and nearly 14 percent of men reported that they had experienced infertility.

As a result of more than a decade of war, thousands of male and female servicemembers are returning home with physical and/or psychological wounds resulting in a variety of fertility and reproductive health issues. Many young servicemembers have been documented with low testosterone levels that can be attributed to the medications that they take for their physical injuries or conditions such as TBI or PTSD. That is why The American Legion supports the draft bill to amend Title 38 to improve the reproductive treatments provided to certain disabled veterans.

The American Legion has always been a vocal advocate of transparency and open communication between the American people and government. Last December, CBO suggested that an annual report similar to the one that DoD produces relative to TRICARE would help policymakers evaluate cost efficiencies. And The American Legion agrees.

Additional data, particularly if it was provided on a regular basis, could help inform policymakers about the efficiencies and cost effectiveness of VHA services. The American Legion through testimony and resolution has consistently called upon VA to maintain transparency in all aspects of data reporting.

This is why we not only support this draft legislation, but we also continue to support H.R. 216 introduced by Ranking Member Brown, the Department of Veterans Affairs' Budget and Planning Reform Act.

Last month, The American Legion commander sent a team of six experts to Los Angeles to work with veterans and learn more about the West Los Angeles land usage agreement. While in LA, we reached out to and worked directly with homeless veterans so that we could get a firsthand sense of the homelessness problem in Los Angeles.

What we discovered was that while expanding the definition of what it means to be a homeless veteran as 627 seeks to do and is something we support, we also realize that there is a large number of homeless veterans that do not qualify for VA services and who are completely overlooked in the administration's goal to eradicate veteran homelessness this year.

Veterans who have less than honorable discharges due to struggles with PTSD or other service-connected issues are not eligible for HVRP or other VA services. The American Legion calls on VA and this committee to address this issue and work with VA to ensure these veterans are properly served.

And finally, in September 2013, The American Legion published our report, The War Within. This report was a result of comprehen-

sive research conducted by our PTSD/TBI Ad Hoc Committee which found that, one, VA and DoD have no well-defined approach toward the treatment of TBI; two, providers are merely treating the symptoms; and, three, DoD and VA research studies are weak in the area of new non-pharmacological treatments and therapies such as virtual reality therapy, hyperbaric oxygen treatment, and other complementary and alternative medicine therapies.

In February of last year, The American Legion conducted a TBI and PTSD veteran survey to evaluate the efficacy of VA's TBI and PTSD medical care and to see how veterans who are suffering from these signature wounds are being treated. The survey showed that 59 percent reported either feeling no improvements or feeling worse after undergoing treatments for their TBI and PTSD symptoms. Thirty-three percent have terminated their treatments and therapies prior to completing them. And the veterans we surveyed reported that they were taking up to ten different medications for PTSD and TBI symptoms.

In June 2014, The American Legion along with *military.com* sponsored a TBI and PTSD symposium and again focusing on complementary and alternative therapies. More information about this symposium can be found in my written testimony.

In closing, The American Legion strongly supports the use of complementary and alternative medicines and supports the funding necessary to assist veterans suffering with PTSD and TBI with complementary, non-pharmacological treatments that allow our returning veterans to actively participate in their own recovery programs without unnecessary sedation or over-medication.

Thank you.

[The prepared statement of Louis J. Celli, Jr. appears in the Appendix]

Mr. BENISHEK. Thank you very much for your comments, Mr. Celli.

Mr. Rowan, you can proceed with your testimony.

STATEMENT OF JOHN ROWAN

Mr. ROWAN. Chairman Benishek and Ranking Member Brownley, excuse my voice. I have been dealing with a cold for the last week. The change in weather is just driving me crazy.

We, too, support all of the proposed legislation before us this morning. The reproductive treatment issue is certainly one we are concerned about. One of the problems that we saw with the Agent Orange issue was the fact that a lot of veterans because of exposure to Agent Orange had reproductive rights issues, that they had terrible problems.

When we had our town hall meetings on Agent Orange, there was a lot of complaints by the wives of miscarriages and stillborns. And so any effort at all to work in that area is a blessing.

The annual report on VHA, I don't understand why that hasn't always been done, quite frankly, and it is just another area that we have been supporting for a long time which is as much congressional oversight as possible is a good thing. And the more information that you have to make your oversight worthwhile will certainly work in that direction.

We support Representative Bilirakis's COVER Act. It is an interesting area for us. One of the things we always complained about years ago when the Vietnam veterans came home, frankly, was the over-medication of Vietnam veterans, way too much Thorazine and not enough treatment, and led to all kinds of problems, not the least of which was some serious issues that ended up with people being put away in jail for a long time.

So the only caveat we might add, we thank the congressman for adding the issue on the membership, but we would also ask that any review may ensure that any alternative treatment have a real scientific evidence background.

Unfortunately, I hate to say it, but there is a lot of people running around saying they have got a cure for PTSD. And while they may have some reasonable alternative medicine or alternative process, some of these things get a little overblown and, unfortunately, can become real scams. So we appreciate the effort, though, and I think this commission can go a long way on that.

Expanding the definition of homeless, that is an issue, you know, not surprising. We need to do more on that issue. There was even a problem out in Long Island where we got homeless veterans a place to live and because they had a place to live, they couldn't get funding because now they had a place to live even though the place was a homeless program. I mean, the VA didn't make sense. They didn't want to fund it. Finally they did, thank God, and I think Congressman Zeldin, one of your colleagues, had a lot to do with that.

So I have been working on homeless veterans since 1981 when they were first discovered in the City of New York. And we applaud the efforts in LA County and we really applaud the efforts of the VA in West LA. They really are starting to make some changes out there. And I am sure Congresswoman Hahn will be pleased to see that.

We support the other programs, the women's treatment program and the retreat sounds extremely interesting. And the expansion of extended care, of course, is something near and dear to us. Unfortunately, many of my members are becoming older obviously and need more of that assistance.

But the main bill we are here for is 1769. We believe this may be the most important bill for veterans since the Agent Orange Act of 1991. And the key to this is the fact that we would begin to finally look at what happens to toxic exposure not only to the veterans but to veterans' families because interestingly enough, if you look at what the VA has already agreed to, male veterans only get children with spina bifida. Female veterans have a much longer list of diseases that affect their children that has been agreed to by the VA often, again, with reproductive issues being the forefront.

So our firm belief that this is so important and having gone out again, we have had over 200 town halls across the country and it has really been discouraging about what we have been hearing from the veterans. But the key aspect of this act is the multigenerational issue. So we not only talk about Vietnam veterans and the effects of Agent Orange, but we talk about the effects of all the folks that went to the Persian Gulf in 1991 and we talk

about all the folks who have been in and out of Iraq and Afghanistan to this day.

We are already getting concerns about some of the folks coming home and some of the effects on their children. So we really, really look forward and we thank you all for the support for this act. Thank you.

[The prepared statement of John Rowan appears in the Appendix]

Mr. BENISHEK. Thank you for your comments, Mr. Rowan.

Mr. Atizado, please proceed with your testimony.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Thank you, Mr. Chairman, members of the subcommittee. I want to thank everybody here for inviting the DAV to testify at this legislative hearing.

As many of you know, DAV is a 1.2 million service-disabled veteran service organization and our mission is to empower veterans to live high-quality lives with respect and dignity. Many of these bills aim to do just that.

We are pleased to present our views on the bills under consideration, but for the sake of brevity, I will only talk about three bills and refer the subcommittee to our written testimony for our position and comments on the others.

First, DAV supports the intent of H.R. 271, the COVER Act. As has been discussed here before, this is a bill that would allow for complementary, alternative medicines to grow in the VA healthcare system. Our resolution from our members calls for access to a complete continuum of services for complementary and alternative medicine.

As part of the Independent Budget, we have long supported the advent of the availability of these therapies in the VA healthcare system for all generations of wounded, ill, and injured veterans, although we do call the subcommittee's attention to the bill's language that may need just a little bit of clarification as to whether the commission that would be established by the bill is expected to study Veterans Benefits Administration claims with regards to mental health disability or whether the claims the bill language uses should be replaced by maybe a more clinically differentiated expression.

The second bill is H.R. 1369 which DAV really does thank Representatives Walorski and Gabbard for introducing. It is a necessary bill. The bill would actually help to address adverse effects that many veterans are feeling right now in the community.

A lot of service-connected disabled veterans who are in nursing homes and skilled nursing facilities are facing very precarious situations where they are not sure who is going to be able to pay for their care because VA is having a little bit of difficulty trying to address their provider agreement authority.

Now, this bill is in line with our resolution and our resolution talks about enhancing long-term services and supports for our members. Our members like with the Vietnam veteran generation and the newest generation are facing services that need to be provided closer to their home and that is one of the weaknesses in the bill that we ask that the committee consider.

Some of these services deal with a specific VA program that is just beginning to expand and because there are problems with VA's authority to implement its provider agreement with private sector providers, that program is being adversely affected.

Finally, we would like to thank the subcommittee for its continued efforts in improving VA's women veterans' healthcare programs and services. We are pleased, definitely pleased to support H.R. 1575.

Now, Congress mandated VA to assess the pilot program which is the subject of this bill and in that assessment, the results describe it as a successful program that improves the ability for women veterans to reintegrate into civilian life.

Making permanent VA's pilot program for counseling treatments for newly-separated women veterans is keeping with our resolution which calls for enhanced medical services and benefits for women veterans.

Equally important is the bill would fulfill a key recommendation to Congress in DAV's report, Women Veterans' Long Journey Home. This report reveals that America's nearly 400,000 women veterans using VA are at risk by a system historically focused on caring for male veterans.

The report paints a compelling picture of federal agencies and community service providers that consistently fail to understand that women are impacted differently by military service and deployment when compared to male experiences.

It also points to challenges that are needed in overall culture and services provided by Federal Government and local communities and it lists 27 specific recommendations.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions you or other members of the subcommittee may have.

[The prepared statement of Adrian Atizado appears in the Appendix]

Mr. BENISHEK. Thank you very much for your testimony, Mr. Atizado.

We have just called for votes, so I was going to ask my questions and then maybe let the ranking member ask and then we will reconvene after votes to conclude. Sorry about the delay here, but they moved votes up apparently.

So I just have a few questions. I want to talk just a minute about the legislation I talked about, to get this annual report. I am trying to figure out what data to get, and I want to try to be able to determine what is the cost of the care that we are providing our veterans through the VA? You know, we don't know; they are spending a billion dollars on a hospital here, a billion dollars on a hospital there, and what does it actually cost them to take care of a patient coming through the door? And I want to find that out because I think we need to, give our veterans maybe more for the money that we are spending in the VA.

So, Mr. Rowan, do you have any further information that you want to present, because you did comment on the bill?

Mr. ROWAN. Yeah, I think that the issue is where our spending is. I mean one of the things that we have had concerns about has been this massive growth of bureaucracy, you know, with the

VISNs and other things, rather than the money being spent on care providers. You know, how much are we actually spending on doctors, rather than managers? How much are we spending on nurses, rather than managers?

And that would be an interesting breakdown to see how that works in the actual provision of services. I mean if we just—if we take the overall budget and just whack it up by the number of veterans, you get a number, but that doesn't give you an idea of what it is being spent on, and that has really been our concern for a long time.

Mr. BENISHEK. Well, it is my concern, too, because I mean if you take the whole budget and the number of veterans that are in the system and you come up with a thousands-of-dollars-per-veteran number.

Mr. ROWAN. Right.

Mr. BENISHEK. But you can't figure out what it actually costs.

Does anyone else have any comment on that?

Mr. ATIZADO. Mr. Chairman, if I remember correctly, CBO's report and their testimony, that you have referred to in your statement when we reviewed that, it was very easy to come to the realization that what you are trying to do is compare one health testimony to another, and in CBO's report they basically say it is nearly impossible.

Now, even if VA were to provide a report like DoD does for TRICARE, CBO even says that might not even do it. There may be some information that VA would be able to provide that is either unavailable or partially available or just nonexistent in the private sector. I believe this is an important question and it is one that really is at the heart of the subcommittee's oversight responsibility. It should be answered, but perhaps it should be posed to the research community. Most of the seminal studies in CBO's report about comparing costs talk about research studies done in the early 1980s, 1990, as early—as late as 2001 and is probably something that should be sent back to them for a little bit closer examination.

Mr. BENISHEK. I appreciate your input because I am trying to get, the right stuff, the right numbers, the right data, so that we can, make some changes to the VA to make it better a0nd more responsive to the needs of veterans. So I am hoping that we can continue to work together to help me find the right data.

Does anyone else have any input there?

Mr. CELLI. I do, thank you.

And The American Legion agrees that while it may be difficult, it is not impossible. And while it may be difficult to completely formulate the type of data that we would need in order to make informed decisions, that doesn't preclude us from starting and gathering some form of data and that has to be a partnership with VA. VA has to be open enough to be able to provide that data when requested and right now we are not seeing that type of transparency when it comes to efficiencies of cost.

We also need to make sure that VA is projecting and programming out efficiently so we can look back then, three, four, five years from now and say, well, this is what VA said that they wanted to do and what they wanted to spend their money on and this is what they wanted to do as far as new projects goes and be able to look

at that and say, well, how did that go? And it is okay for it to change, but without a plan, then it is almost reckless.

Mr. BENISHEK. Thank you. I am going to yield back my time, and we will give Ms. Brownley some time here before we run off to votes. Thanks.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Mr. Rowan, you testified or mentioned the fact that based on some data that women were suffering a lot more in terms of their reproductive health because of exposure to any kind of toxic material. Do we have any hard data on that in terms of exposure for women, specifically?

Mr. ROWAN. You know, I don't know if there is exact data, but when you look at the presumptive illnesses that VA has agreed to, men only have spina bifida where the women have several, most associated with their reproductive organs and their issues and effects on those, and that is intriguing to me, why the women have that problem, but not the men. I mean, you know, because there is really a lot of concern about the genetic effect of toxic exposure which may lead to all kinds of genetic problems carried over into the next generations. So that is why we think that it is important that we take a look at all of that.

You know, there were several states that were starting to do that many years ago back in the 1970s and 1980s, New York, New Jersey, Michigan, I think, started to look at that, but then, unfortunately, there was no funding for it and nobody wanted to keep up with it. And they were starting to look at the data of the children of Vietnam veterans, and they may need to go back to try to find some of that, if it still exists or take a look at new ones. And we are really concerned not only about us, but looking forward.

Persian Gulf have been out 20 years now, so there should be a lot of data on them. And the new folks, we should start tracking them now, you know. I always tell the anecdotal story, I have a cousin who is, you know, in his early 40s as a Seabee Reservist, went to Iraq twice, dealt with all kinds of horrible cleanup stuff, dealt with all kinds of exposures. He came home, and after his second tour, he got non-Hodgkin's lymphoma and his third child was born with downs syndrome. Now, is there a connection? I am not a scientist. I can't tell you for sure, but somebody ought to study it and that is what we are just saying.

One of the problems we have had with the whole Agent Orange issue is for all these years, they have never really done a decent study. They have never really done a decent scientific review. IOM has been relying on all kinds of extraneous studies done around the world to come up with all of these things and we have waited all these years. I mean I am going to be 70 in September and, you know, it only took three years ago when they added ischemic heart condition. I mean I don't want to see that happen to the Persian Gulf vets and I certainly don't want to see that happen to the new vets, that they have to wait 40 years to find out that they have problems with their children, that they need to take a look at.

Ms. BROWNLEY. Absolutely. I couldn't agree more with your comments.

I also wanted to just ask the whole panel, based on Ms. Brown's bill, H.R. 1575, what are your thoughts—the VA made a sugges-

tion, I think, that we should, in terms of expanding the population of eligible veterans, that we should also include men, as opposed to strictly women. Does anybody have a comment with regards to that?

Mr. ROWAN. I will be honest, I am not an expert in this field—I never really followed up on it—but that was my first reaction when I read the bill and looked at that pilot program as, gee, a retreat form. That is not a bad idea, but why do we do it just for women? Why not men as well?

I remember former Chairman Filner when he was here, one of the things he talked about was reverse boot camp. You know, the idea of we bring people home—we spend all this time and effort and money to make people into warriors and then when they come back, we don't spend a nickel to make them into civilians again; that is an interesting concept.

Ms. BROWNLEY. Any other comments from——

Mr. CELLI. Yes, I would like to dovetail on what Mr. Rowan said. During World War II, after veterans left combat, they had a three-or-four-week journey back on a boat to reintegrate with their platoons and really decompress. Right now, you can go from the battlefield to your living room in 15 days, 10 days, 5 days in some cases, and veterans really need that time to decompress. And I think that is a huge component of some of the illnesses that we are seeing now just being exasperated; they don't have time to deal with it.

Ms. BROWNLEY. Do you think that if we included men and women, that we should keep them separate, men going together to one place and women going together in another?

Mr. CELLI. Congresswoman Brownley, I cannot answer definitively whether it should be a separate cohort in each retreat. But I do know this, the idea of having a retreat specifically for women veterans really came out of the idea that they are such a small population compared to the overall veteran population, and because they are so small, their ability to support each other and have some kind of peer support group to learn from each other's experiences became all the more important.

Now, whether that would apply to male veterans with that specific respect may not necessarily be the case, but I would hope that VA would have some kind of reasoning, other than, well, that is another part of the population for male veterans to be put in a retreat setting.

Ms. BROWNLEY. Thank you. I am over my time and I yield back.

Mr. ROWAN. If I might add, Congresswoman, the other issue here is I would remiss—my vice president would take me to task—she ran a program in Philadelphia for women veterans and she would be the first one to tell you that unfortunately homeless women veterans have a high-rate of military sexual trauma and that may be a perfect reason why they need to be taken on separately, as from the men, to give them that space to be able to deal with those issues that they may not be willing to deal with.

Ms. BROWNLEY. Thank you.

Mr. BENISHEK. Gentlemen, I am going to ask your indulgence. We are going to have to go into a recess to do the votes, and we

will reconvene as soon as possible after the votes are over. Thank you.

[Recess.]

Mr. BENISHEK. The subcommittee hearing is back in session. Since we don't have any other members, I am going to ask a few more questions of this panel here, since I have some time, and I think Ms. Brownley may have a few more questions, too, and see if any other folks show up to ask their questions.

I was just going into this question of the reproductive treatment that we hope to provide for disabled veterans. Some of the testimony in the record suggested that, there should be included surrogates and third-party donations. I understand the reason for those, but the DoD doesn't provide those benefits and the VA has expressed some concern in previous hearings, on this issue. So I am just wondering how we are going to deal with this going forward, and does anyone here have any other concerns about the complexities that would be involved with the addition of a surrogacy provision in the draft bill. I know, Mr. Ortner, you probably have another comment to make on that.

Mr. ORTNER. Yes, Mr. Chairman. You know, the approach of PVA has always been to—that the VA and DoD should try and bring someone with a disability, especially a catastrophic disability, as much of a recovery as they can. Their quality of life should be back to as much as normal as it can be. Now, of course, you know, in our written testimony, we commented on the challenges of the individual's who has got a catastrophic SCI where they may have been able to have IVF, but they are not going to be able to carry it to term. And the concern we have on this situation, is that even though DoD doesn't supply it, we think DoD should. Because you have still got a situation of an individual that lost the ability to have children due to their service and we also see it as being probably a very, very small number of individuals that are going to have this condition, which is primarily why we, in our testimony, we talked about there needs to be a little clarification. Because, obviously, it is probably not something you just say, well, we are going to open it up and anybody can have a surrogate. But we probably think there are those situations where you have got those situations where that individual is unable to carry the child that should have a consideration.

Regarding the genetic material, that is another thing, third-party genetic material. We think there is probably a very unique situation where you are going to have, possibly, you know, individuals that are going to suffer from something that causes a damage to the genetic material. But as we saw with Gulf War syndrome, as we have seen with the various toxic substances is that you experience in service, you can have that situation. Essentially, what we are doing is because if someone serves, they have lost that ability to have children and we think they should have that.

Mr. BENISHEK. All right. Thank you. Anyone else have anything further on that?

Mr. ROWAN. No, I would just concur with what the gentleman was saying in that regard. Clearly, the in vitro fertilization is one aspect of it, but our concern is going back to the toxic exposure issue is the effect of genetic material on exposures. But the issue

of women, especially who have been hurt in the military and the impact on them is interesting. Because, I was relating a story, I had a client when I was doing service-prep work back in the twos, early twos, who, she had only been in the Army like a year and a half and then broke her hip severely and they did a mediocre job in putting her back together, quite honestly, and she was having some issues with it.

We got that dealt with, but then when she got pregnant, she was very concerned about whether or not she was going to be able to carry a baby to term, whether it would affect her—what the hip would do, how she would get around. And, unfortunately, this was the early days of women's programs inside the VA, but we managed to get her help. But it, clearly to me is one of those things that the PVA people are well-aware of and we would support any effort to assist those folks.

Mr. BENISHEK. Well, thank you very much. I will yield back the remainder of my time.

Ms. Brownley, do you have any more questions for the panel?

Ms. BROWNLEY. Just one quickly. I just wanted to first comment that—and to applaud Mr. Bilirakis and Dr. Ruiz and Ms. Walorski for their bill on alternative approaches to mental health issues. You know, one part of that bill is looking at outreach efforts to veterans for mental health services, and in my mind, I feel as though that is an extremely, extremely important component because, I think particularly for our Vietnam veterans and our older veterans, getting them to mental health, but getting them to the place where they feel comfortable seeking the help is probably 90 percent of the issue. And so, you know, how do we encourage and make it feel right and say for our veterans to seek that health out. So I think that is really, really important.

I just wanted to ask the panel, and really all of you, you know, the VA continues to talk about the work that they have been doing and continue to do around alternative therapies for mental health. I know we have an extraordinary program in my district with equine therapy that has been very successful for our veterans. I am just wondering, at this juncture, how would you grade the VA in terms of how well they are/we are doing with regards to alternative approaches to mental health. Just, you know, a quick response, no—it doesn't have to be evidence-based, just your general reaction to what would you give the—what grade would you give the VA?

Mr. CELLI. I can tell you that based on the firsthand research that The American Legion has done, the grade would not be superior. I think there is a lot of work to be done. I think that the VA is looking at those options and it is something that we are interested in looking at with them, similar to things like this bill.

You know, the VA has come a long way with things like the vet centers, which have really taken this issue head-on, during the time of Vietnam, when Vietnam veterans were coming back. They have vocational rehabilitation, which has almost an endless supply of resources to help veterans rehabilitate back into society. Maybe they could look at some kind of mental health center that is unique to PTSD. You know, maybe if there was a specific PTSD program that charged these centers with looking at alternative therapies, trying to get them off medications and graded them based on suc-

cess rates, maybe there would be some more out-of-the-box type of thinking.

Ms. BROWNLEY. Do you still believe that outreach is a critical component to——

Mr. CELLI. Absolutely. Ninety percent of the veterans that we spoke to did not know what their options were. And we need to make sure that stakeholders, Congress, VA, the American public in general, knows that—or is able to communicate to veterans and participate in that outreach to let them know what their options are. And, again, vet centers is a wonderful tool to help do that; it is probably the best kept secret in VA.

Mr. ROWAN. Clearly, the vet centers, we helped establish those things, and I remember back in the Reagan years, trying to fight back the OMB from killing them. Thankfully we succeeded, but the problem we always had with them is they only focused on the veteran. They didn't do enough to bring the family into the picture.

I must tell you that my colleagues in Australia—I have been doing family counseling with the veterans for 35 years—and that would help a lot if that was added, so that they would be able to work with spouses, children, whatever; the whole secondary PTSD issue is a big issue.

As far as outreach, the VA has got a very bad mark. I would give it an F. I don't think they do anywhere near enough of outreach.

And, frankly, all the alternative stuff is done by private-sector organizations, and the one thing about—hopefully with Bilirakis' proposal with this commission is that they would review all of those things and really try to understand what are really scientifically attainable and what are not, and what are just figments of people's imagination. I mean, don't get me wrong, I love my dog and, you know, if I hang out with my golden retriever, he has a lot of fun and he can certainly lower my anxiety levels, but the bottom line is that without a treatment program on top of that, it is not enough. So complementary is the keyword there and alternative, not instead of.

Ms. BROWNLEY. Yes. Any other comments from any other panelists?

Mr. ORTNER. Well, we have only got a couple of seconds, but I think the biggest challenges with the VA—I kind of go a little more with the Legion. I would give them maybe a C. But I think it is—I think part of the challenge with the VA is it is a huge bureaucracy; bureaucracies are resistant to change. And I think in the case of the VA, they are more concerned about having an embarrassment from a fraudulent program than they are necessarily helping every veteran.

And that sounds negative, but I don't mean it in that way. It is just like Mr. Rowan mentioned, which I worked on back in the 1990s, a lot of fraudulent things going on and quack medicine. There is reason to be resistant, but I think that is one of the challenges with the alternative things.

As for outreach, that is absolutely critical. I worked homeless issues back in the mid-1990s, and the outreach was key, but it really wasn't the VA doing the outreach; it was the homeless centers and things like that, that were doing the outreach, funded by the VA. But a lot of that has to do with mental illness, getting out

there and interacting with those people, and that can be challenging because there is a lot of fear going into those environments to deal with that.

Ms. BROWNLEY. Thank you for watching the clock for me. I yield back.

Mr. BENISHEK. Thanks. Ms. Titus, you are recognized for five minutes.

Ms. TITUS. Well, thank you, Mr. Chairman. And thank you and the ranking member for allowing me to sit in today.

I want to agree with the ranking member, Ms. Brownley's comments, that we need to expand this legislation. I hope that we can work together to be sure these treatment options are available for all our veterans. As it is currently written, it is possible that there are veterans who meet all the requirements contained in this draft legislation, such as having a service-connected disability that prohibits procreation, but due to their sexual orientation, they won't be able to receive this assistance.

Now, I would like to ask the members of the panel if they have any concerns that this legislation fails to offer services to legally married same-sex couples. Mr. Ortner, you mentioned some exceptions that might be needed to be considered. You mentioned surrogacy and third-party genetic donations, but what about same-sex couples, if they are denied these benefits as veterans, is that really fair? So I would ask you all to comment on that.

Mr. ORTNER. Well, Ms. Titus, PVA does not have a position on that, and I am not in a position to comment due to that.

Mr. BENISHEK. Who wants to jump in? Okay.

Mr. ROWAN. The bottom line for us has been when we have dealt with gay rights issues, quite frankly, is if the law allows it, we are in favor of it. I mean it started when they finally allowed people to come into the military openly gay.

Ms. TITUS. Yes.

Mr. ROWAN. I mean if you are going to let them in, they are a veteran when they come out. So if they are a gay veteran, they are a gay veteran. I mean I think that there is a lot of adjustment society is going to be making over the next decade or so on these issues.

We got involved when we talked about the spousal benefits questions and that got interesting real fast. And, you know, obviously, some people have very strong opinions on that and they are not going to be in favor of it, but our feeling was just simple: if it is the law, then it is the law and it ought to cover every veteran, not one or—some veterans yes, some veterans, no.

Ms. TITUS. Okay.

Mr. CELLI. The American Legion has a similar view. We have a resolution that states that there should be equality amongst all veterans and all generations of veterans. So if they are a veteran and they apply for VA services, they should be entitled to the same VA services as any other veteran.

Ms. TITUS. I am glad to hear you say that.

Mr. ATIZADO. Thank you, Congresswoman Titus. I will tell you this, the mission of the DAV is very clear. What we are about is making sure that any service injury that a veteran sustains while performing honorable service for this nation, should be given the

opportunity to be given high-quality life, and as I mentioned, to lead it with respect and dignity. So if a servicemember happens to have a certain sexual orientation, but they are injured and unable to have a—are injured and have reproductive difficulties, while we don't have a specific resolution on it, based on our mission, we would like to ensure that that member have the same and enjoy the same benefits as their counterparts.

Ms. TITUS. Well, thank you. That seems to me only fair: A veteran is a veteran is a veteran, and all veterans deserve equal benefits. Many states now recognize marriage equality and it is very likely that the Supreme Court is going to be making that decision here this summer, so we want to be sure that we don't enact policy that discriminates and doesn't provide benefits that all our veterans have earned. So I appreciate hearing your comments on that and I yield back.

Mr. BENISHEK. Thank you, Ms. Titus.

In the absence of any further questions, the panel is excused. Thank you very much, gentlemen.

I will now call up the third panel. This is Dr. Rajiv Jain; he is the assistant deputy under secretary for health for VA Patient Care Services.

Thank you, Dr. Jain for coming and waiting for awhile as we concluded our voting procedures there. You may proceed with your testimony when you are ready.

STATEMENT OF RAJIV JAIN, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JANET MURPHY, ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JENNIFER GRAY, ATTORNEY, OFFICE OF THE GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF RAJIV JAIN, M.D.

Dr. JAIN. Well, thank you, Mr. Chairman, Ranking Member Brownley, and Members of the Committee. Thank you for inviting me here today to present our views on several bills that would affect the Department of Veterans Affairs programs and services.

Joining me today to my right is Ms. Janet Murphy, acting deputy under secretary for health for operations and management, and to my left is Ms. Jennifer Gray, attorney in the Office of General Counsel.

I would like to start with Chairman Benishek's bill, to amend the Title 38 United States Code to direct the secretary of veterans affairs to submit an annual report on furnishing of hospital care, medical services, and nursing home care by the Department. We support this bill and are already providing much of this information on our Web site and through the mandated reports to Congress. The costs associated with this and other bills on the agenda are included in my written statement, so I won't go through them now.

The VA also supports H.R. 627, a bill to amend Title 38 that expands the definition of homeless veteran for purposes of benefits under the laws administered by the secretary of veterans affairs. This will align us with HUD's definition of homeless.

Regarding H.R. 1369, VA appreciates the Committee's interests in updating our authority to purchase extended care services from the community providers. We are currently developing a legislative proposal to address our authority to purchase hospital care, medical services, and extended care services. We look forward to working with the Committee on this vital legislation.

We support the concept Congressman Miller's draft bill to amend Title 38 to improve the reproductive treatment provided to certain disabled veterans. We would like to expand the language, however, to include all veterans who might be eligible.

VA supports H.R. 271, a bill to exam the efficacy of VA treatment of mental disorders and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veteran Affairs medical facilities within the community; however, we have concerns with some of the language that may interfere with the stated goals of the bill. We would like to work with the Committee to amend the language.

We support the intent of H.R. 1575, a bill to amend Title 38 to make permanent the pilot program on counseling and retreat settings in women veterans, newly separated from their service in the Armed Forces. While VA agrees that providing these retreats is beneficial to women veterans, it should be made permanent. Other veteran and servicemember cohorts could benefit from this treatment modality.

As discussed in previous hearings, while we support the efforts to enhance research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in Armed Forces, we are unable to support this bill because a center would duplicate the efforts of other federal agencies and other reasons that are discussed further in our written testimony.

Finally, I would like to say to give the VA its best view, we have worked in collaboration with many agencies to solidify the views provided on many of the bills discussed today.

Thank you, Mr. Chairman, for the opportunity to testify before you today. My colleagues and I would be pleased to respond to any questions that you may have.

[The prepared statement of Rajiv Jain, M.D. appears in the Appendix]

Mr. BENISHEK. Thank you, Dr. Jain, for coming and for your testimony and comment.

I am going to yield myself five minutes for questions. Dr. Jain, the VA opposes this H.R. 1769 on the grounds that other federal departments and agencies are poised to support research on multigenerational health effects of toxic exposures. The VA's research programs have been praised elsewhere in this hearing and are, I am sure, more than up to the tasks set forth in the bill. What is more, the VA's testimony lists the VA War Related Illness and Injury Study Center, the VA Office of Research and Development, and the VA Office of Public Health, among those whose work would

be duplicated, according to the VA by the national center proposed in H.R. 1769.

I have a couple of questions that follow up with that. What other departments or agencies do you think are better positioned to study the effects of toxic exposure on veterans and their descendants than the VA and why?

Dr. JAIN. So, thank you, Mr. Chairman, for that question. I think I wanted to, again, make it very clear that we certainly support all of the work that needs to be done to find out if there are any impacts from the exposure to toxic agents for veterans and their descendants. So, in general, we are completely in agreement in doing whatever we can do and we must do.

The concern comes into play, sir, if you really look at these disorders that happen from exposure to toxic agents, they are extremely rare. So you need large populations to really come to any meaningful conclusion of the cause and effect. So a lot of our experts feel that the exposure in the civilian setting and the exposure in the military setting has a lot of parallels where we can learn from both sets of exposures. And so having, for example, the national center for—the National Institute of Environmental Health Sciences or The Center for Disease Control that also have significant efforts in looking at that, if we could structure a solution that could collaborate and partner with those agencies, we could maybe have a better chance in achieving scientifically proven impacts that I think would——

Mr. BENISHEK. I don't think there is anything in the bill that excludes.

Dr. JAIN. Right.

Mr. BENISHEK. You know, it is a research coordination bill; although, I don't think it excludes getting data from anywhere.

Dr. JAIN. It wasn't clear, sir, but I think if the intent is that the Center could work with other agencies and could begin to have that broader sense, then that could be something we can definitely look at.

Mr. BENISHEK. Okay. Then let me ask you another question here. What does it say about what is going on in the VA War Related Illness and Injury Study Center and the VA Office of Research and Development and the VA Office of Public Health? I mean shouldn't we coordinate all of that in one place to explore toxic exposure issues?

Dr. JAIN. That, we would agree with you, sir. The only point that we were making is that we have these areas, the war related centers, the ORD, all of these departments are constantly looking at the published literature. They are trying to understand what is going on.

Mr. BENISHEK. I understand why you say that, but, you know, they also said that focusing solely on military exposures would likely result in inconclusive research. Well, a lot of people in the civilian life weren't exposed to Agent Orange. Most people were exposed in the military setting.

And it is similar—and it is very difficult—I would say in the burn-pit situation, most of the people that were exposed to toxic fumes in burn pits, that doesn't seem, to me, a very common civilian exposure. Now, there may be other exposures that are more

common in the civilian life than there are in the military; I would say maybe lead exposure would be maybe an example of that. But there is lead exposure in the military, and maybe that could be coordinated. You know, depleted uranium exposure doesn't occur that often. I mean there are lots of things that are kind of specific to the military, Dr. Jain, and that I think really doesn't—you know, your argument really doesn't wash with me, okay. So I think that is not a very good reason to be advocating against a legislation, in my opinion.

Do you have any rebuttal for my comment there?

Dr. JAIN. No, sir. The only thing that I would offer that I was going to suggest, sir, is that if we could have an opportunity to work with you and the Committee, to work with some of this language, so that we can achieve some of the goals that we are looking for. That is all we are saying. But we agree with what you are saying.

Mr. BENISHEK. Yes. Well, I am happy to have you involved in the process, Dr. Jain. We just want to make some progress here.

Dr. JAIN. Absolutely.

Mr. BENISHEK. In view of time, I am going to ask—I am going to ask the ranking member if she has any questions.

Ms. BROWNLEY. Thank you, Mr. Chair.

And I will just follow up on your line of questioning regarding your bill. Mr. Jain, you have testified that these exposures are so rare it is hard for you to come up with a scientific response. But what exposures do you define as rare?

Dr. JAIN. Well, I am not talking about the exposure is rare, but what I am saying is that the science indicates that when you look at diseases or conditions caused by toxic agents, those are rare, because you get into play the genetic factors, heredity, age, the time of exposure, duration of exposure, the type of agents, so there are a lot of agents. So I think my only point is that these are rare conditions, so you need larger sets of populations. So whatever solution we come up with, I think as long as we have access to the largest population base that we can think of so that we can get to the real bottom of this, I think is all we are saying. So, we are supportive of that.

Ms. BROWNLEY. Yeah. I would just say that I think in this case, you know, it is the VA and government in general that I think has to take a lead on these issues, and if we don't, who will? I think it is just our responsibility, you know, to do so.

So another question I wanted to ask with regards to H.R. 627 with homelessness, in response to domestic violence in veterans' homes, you are saying that you are already serving these veterans; it is not so much of a problem, yet you lacked the detailed data regarding the size and the characteristics of this population. So, can you explain to us how you know that you are already serving this population?

Dr. JAIN. So, I think I am going to turn to my colleague, Ms. Murphy. She is more familiar with this topic. Janet?

Ms. MURPHY. Thank you, Congresswoman.

So, we collect a lot of data on the veterans that we serve in our homeless programs and, fundamentally, any veteran who needs—we don't turn down veterans who need homeless services, so we

don't distinguish that you are fleeing domestic violence, so we can't serve you. So we are already serving those veterans.

How many? We would have to come back—take a look at that and come back with that information for you. I think this is really a technicality, is correcting the law so it is codified in law and consistent with HUD language, the language in HUD's regulations, that we are all—because that is our very strong partner in all of this. But we are already serving those women veterans and men as well, because men also flee from domestic violence. So we will continue to do that and we will see if we can find information which quantifies that for you.

Ms. BROWNLEY. So when you say you don't turn anyone down, a homeless veteran who needs permanent housing or temporary housing, you don't turn anyone down, but there is not enough housing for the homeless veteran population, at least in Los Angeles County there is not, and I think in my county, in Ventura County, it is the same.

Ms. MURPHY. We don't turn anyone down in terms of access to services, then the challenge becomes to find them the housing. We have plenty of HUD vouchers. We have vouchers available to provide them housing. The challenge is finding the housing, particularly in areas like Los Angeles, San Francisco, Seattle, but, you know, we continue to work the problem.

Ms. BROWNLEY. And you are also saying that you don't collect that data in terms of bifurcating within the homeless population of veterans, who of the veterans are—who have—who are there because of domestic violence.

Ms. MURPHY. I need to verify that. We collect a lot of data on our population that we serve and I would need to clarify whether we collect that specific data and whether that was—we were able to tease that out and make that available.

Ms. BROWNLEY. Well, I would appreciate it.

Ms. MURPHY. We certainly should be collecting it, if we are not.

Ms. BROWNLEY. And if you would, get back to me or the Committee with that information, I would appreciate it.

Ms. MURPHY. Absolutely.

Ms. BROWNLEY. I yield back.

Mr. BENISHEK. Thank you.

Ms. Titus, you are recognized.

Ms. TITUS. Thank you, Mr. Chairman.

Dr. Jain, I would just go back to the point that I was making earlier that I worry that Chairman Miller's bill is written in such a way that it denies benefits to certain veterans. And I appreciated your comment that you would like to see it expanded so that you could serve all veterans.

Do you agree that the legislation, as written now, would not offer options to same-sex couples who might need help starting a family?

Dr. JAIN. Thank you for that question, Congresswoman. This has a lot of legal implications, so I am going to turn to my OGC colleague, Jennifer, to address that.

Ms. TITUS. Okay.

Ms. GRAY. Yes, thanks, Congresswoman.

You have raised some important questions on an important issue with this legislation, and we will need to research this further, but

we are more than happy to discuss the applicability of this provision with you at a later date once we have looked into it a little bit more.

Ms. TITUS. You needed help to say that, Dr. Jain.

Dr. JAIN. Let me just clarify. I think that there is no question that we feel that restoring the physical and mental capability of our veterans is a very important mission of the VA. And the ability to be a biological parent is very important for one's mental and physical well-being and sense of well-being, so we are very much in support of this concept and I think that if the thought is to begin with the most severely injured veterans first, we certainly understand that. But at some point, we do feel that the who IVF technologies should be made available to a broader group of veterans who have medical and other reasons for not being able to be a biological parent. So I am just stating to you the broader sense that we have, but there are some legal issues with that, and that is why I wanted to turn to my colleague.

Ms. TITUS. I appreciate that, and I would thank you very much if you could get back to me on that so we could work together on this to be sure that all our veterans receive the benefits that they serve.

Thank you, I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you, Ms. Titus.

I have just another question I want to ask Dr. Jain, too. In the written testimony, Dr. Jain, you stated that the VA appreciates the intent of the draft bill to direct VA to submit an annual report on the Veterans Health Administration, but notes that the bill may be unnecessary as the data and related measures contemplated by the bill are already compiled as part of an ongoing, automated process for data that are available publicly; yet, in the testimony before the subcommittee in January, the Congressional Budget Office stated that the VA provided limited data to the Congress and the public about its costs and operational performance, and that if it was provided on a regular and systemic basis, it could help inform policymakers about the efficiency and cost-effectiveness of VHA's services. So similar sentiments were also issued by the Independent Budget and The American Legion and by others during testimony on the first panel.

Can you explain the discrepancy between what you said in your testimony and the testimony of the Congressional Budget Office and the others regarding the VA's record of transparency?

Dr. JAIN. Sir, so this, you could consider this, in part, an evolution, I guess, you could say in our thinking. But the current secretary has made it very clear that we want to be transparent. And as you know, sir, the impact of a lot of the Choice Act legislations, we are in the process of preparing a lot of the reports, so when we saw your bill, we certainly understand the intent of what you want, but our only clarification that we would like to work with you and the Committee, is to understand what you are looking for so at the end of the day we can give you and you are satisfied with the report. That is the only hesitation of the——

Mr. BENISHEK. Right. Right.

Dr. JAIN. Yes.

Mr. BENISHEK. Well, I think, you know, if you are already compiling the data that is required in the bill, presumably that information could be compiled into a report and provided to us.

Dr. JAIN. We are and, yes, that is correct.

Mr. BENISHEK. It seems to me that the information—that you may have the information, but it is not compiled in a way that makes any sense to us. And, basically, what I am trying to figure out is what somebody else mentioned here, too: How much money are we spending on nurses and doctors and how much money are you spending on bureaucrats? Most hospitals and other people around the country who provide healthcare, they can define those kinds of numbers. The VA doesn't. I want to be sure that the billions of dollars that we are sending to the VA gets spent in the most effective way that gives the most care to our veterans and it is not being eaten up by a bureaucracy.

And I think that we don't have access to those kinds of numbers, Dr. Jain, and those are exactly the kinds of numbers that I am asking you for. Where is the money going and how are you compared to everybody else in spending these billions of dollars that we send to the veterans healthcare?

Dr. JAIN. Absolutely, sir. I think once we can work with you and the Committee to understand your needs—we don't have that data ready-made; that is the difference, I think, is what I believe what was stated in the previous testimony. And we don't have it today, either. We have pieces of that, but if we understand your needs, we are willing to work with you and to provide to you——

Mr. BENISHEK. Well, I am glad that you agree with me that there is more data——

Dr. JAIN. Right.

Mr. BENISHEK [continuing]. That VA needs to provide to policymakers so we can make better decisions.

Dr. JAIN. Yes, sir.

Mr. BENISHEK. So I am happy to hear that from you.

I am going to yield back, and does anyone else have any other questions that they would like to ask?

Well, thank you very much, Dr. Jain for being on the panel.

Thank you for being here, and all the others, and for those who attended as well. We may be submitting additional questions for the record, and I would appreciate your assistance in ensuring that an expedient response to these inquiries is given. And with that, if there are no further questions, the third panel is excused.

I ask unanimous consent that all members have five legislative days to revise and extend their remarks and exclude extraneous material. Without objection, so ordered.

I would like to thank, again, all the witnesses. The hearing is now adjourned.

[Whereupon, at 12:46 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE CHAIRMAN JEFF MILLER

It is a pleasure to be here today with you, Subcommittee Ranking Member Brownley, and other Members of the Subcommittee on Health as well as with representatives from our Veterans Service Organizations (VSOs), interested stakeholders, and audience members to discuss my draft bill to improve the reproductive treatment provided to certain disabled veterans.

The conflicts in Iraq and Afghanistan over the last decade have resulted in significant increases in reproductive organ and spinal cord injuries among our servicemembers.

These wounds can have serious and life-long repercussions on the daily lives of our veterans and their families, not the least of which can be the inability to conceive a child.

While the Department of Veterans Affairs (VA) does provide a number of fertility services to veterans, VA is currently prohibited via regulation from providing In Vitro Fertilization (IVF), one of most well-known and arguably most effective assisted reproductive technologies.

The VA is also prohibited by statute from providing any such treatment to a veteran's spouse.

In contrast, the Department of Defense has been providing IVF to severely wounded servicemembers since 2010.

What this disparity results in is severely disabled veterans having to decide whether or not to pursue a family though IVF before they separate from service-while still actively recovering from their wounds and during what can be a highly stressful transition period-or pay for the procedure out-of-pocket once they move to veteran status.

Because IVF can be costly, for some veterans, waiting until they are in VA care can mean having to choose between financial freefall or forgoing their dreams of having a child altogether.

That is an agonizing and unacceptable choice that this draft bill would help prevent veterans with these disabilities from ever having to make.

The draft bill would authorize VA to provide assisted reproductive technology, in addition to any fertility treatment already authorized, to enrolled veterans whose service-connected disability includes an injury to the reproductive organs or spinal cord that directly results in the inability to procreate without the use of assisted reproductive technology.

Assisted reproductive technology is defined in the bill to include IVF as well as other technologies determined by VA as appropriate to be used to assist reproduction.

In furnishing IVF or similar procedures to an eligible veteran, VA would also be authorized to provide services to that veteran's spouse.

Like DoD, VA would be limited to providing eligible veterans three in vitro fertilization cycles, resulting in a total of not more than six implantation attempts.

The draft bill would further stipulate that VA is authorized to provide for storage of genetic material for three years, after which the veteran and his or her spouse is responsible for the costs of

such storage; that VA cannot possess or make any determinations regarding the disposition of genetic material; and, that VA is required to carry out activities relating to the custody or disposition of genetic material in accordance with the relevant state law.

Finally, the draft bill would prohibit VA from providing any benefits relating to surrogacy or third-party genetic material donation.

In short, this legislation mirrors the IVF benefit that is provided to active-duty servicemembers in DoD, creating parity between the two Departments while opening the door to parenthood for disabled veterans who may otherwise not have the resources to pursue such a path.

I am proud to say that this proposal is supported by many of our VSOs, by RESOLVE: The National Infertility Association, and by the American Society for Reproductive Medicine.

I thank them all for their support of this draft and for their thoughtful comments and recommendations for how it may be improved.

I look forward to working hand-in-hand with Subcommittee Members to address those suggestions and otherwise strengthen the language in the draft bill before it is introduced and moved forward.

This draft is derived partly from the recent Subcommittee roundtable where infertility among disabled veterans was discussed in depth and I am grateful to you, Dan, for holding that roundtable as well as this hearing today.

I urge all of my colleagues to join me in supporting this draft bill and, with that, I yield back.

PREPARED STATEMENT OF THE HON. GUS M. BILIRAKIS

Chairman Benishek, Ranking Member Brownley, and members of the Health Subcommittee,

Thank you for holding this very important hearing and for the opportunity to discuss my bill, H.R. 271, the Creating Options for Veterans' Expedited Recovery (COVER) Act.

With statistics showing that one in five Veterans who served in Iraq and Afghanistan have been diagnosed with Post-Traumatic Stress, we must responsibly ask ourselves—are we doing enough when it comes to addressing mental health in our Veteran population?

Recent data has shown that every day in this country—an estimated 18–22 Veterans take their own lives. This statistic answers the question I posed earlier. It is obvious more needs to be done. That is why I reintroduced the COVER Act in the 114th Congress.

The COVER Act will establish a commission to examine the Department of Veterans Affairs current evidence-based therapy treatment model for treating mental illnesses among veterans. Additionally, it will analyze the potential benefits of incorporating complementary alternative treatments available within our communities.

The duties of the commission designated under the COVER Act include conducting a patient-centered survey within each Veterans Integrated Service Network. The survey will examine several dif-

ferent factors related to the preferences and experiences of Veterans with regard to their interactions with the Department of Veterans Affairs. Instead of presuming to know what is best for Veterans, we should simply ask them and work with them on finding the right solutions that best fits their unique needs.

The scope of the survey will include: the experience of a Veteran when seeking medical assistance with the Department of Veterans' Affairs; the experience of Veterans with non-VA medical facilities and health professionals for treating mental health illnesses; the preferences of a Veteran on available treatments for mental health and which they believe to be most effective; the prevalence of prescribing prescription drugs within the VA as remedies for treating mental health illnesses; and outreach efforts by the VA Secretary on available benefits and treatments.

Additionally, the commission will be tasked with examining the available research on complementary alternative treatments for mental health and identify what benefits could be attained with the inclusion of such treatments for our Veterans seeking care at the VA. Some of these alternative therapies include, among others: accelerated resolution therapy, music therapy, yoga, acupuncture therapy, meditation, outdoor sports therapy, and training and care for service dogs.

Finally, the commission will study the potential increase in health claims for mental health issues for Veterans returning from the most recent theatres of war. We must ensure that the VA is prepared with the necessary resources and infrastructure to handle the increase in those utilizing their earned benefits to address the mental and physical ailments incurred from military service.

Once the Commission has successfully completed their duties, a final report will be issued and made available outlining its recommendations and findings based on their analysis of the patient-centered survey, alternative treatments and evidence-based therapies. The Commission will also be responsible for creating a plan to implement those findings in a feasible, timely, and cost effective manner.

Last Congress, I was very pleased this subcommittee considered the COVER Act in a legislative hearing. At this hearing, all the Veterans Service Organizations (VSOs) and organizations testifying had supported the COVER Act. I want to thank you all again for your support through your testimonies given today.

In closing, we have the support from Veterans and the organizations that work closely with them. And it is clear that there is a need to do more in how we—as a nation—address these challenges. The responsibility is ours. The question now is—what do we intend to do about it. With that, I urge all my colleagues to show your support for our nation's heroes by signing onto H.R. 271. Let's get this done for our Veterans and let's work together on finally getting them "covered."

PREPARED STATEMENT OF HON. JANICE HAHN

I would like to thank this Subcommittee, especially Chairman Benishek and Ranking Member Brownley—two friends of mine—for holding this important hearing.

Homeless veterans are a pressing problem for this nation. More than 62,000 veterans are homeless on any given night, and over 120,000 veterans will experience homelessness over the course of the year.

While only 7% of Americans qualify as veterans, veterans make up nearly 13% of the homelessness population.

Sadly, my home of Los Angeles County has the most homeless veterans in the nation.

Today, I want to address one segment of homeless veterans—those who are homeless because of domestic violence. Currently, the Department of Veterans Affairs' definition of homeless veterans does not include veterans who are homeless because of domestic violence.

Across the country, too many victims of domestic violence feel that there is nowhere for them to turn. Lacking resources, help and a safe place to go, some victims stay with their abusers.

Tragically, too often women veterans are among those who find themselves in this horrible situation. According to the VA, 39% of our women veterans report experiencing domestic violence, well above the national average. However, because of antiquated laws on the books, they have not been eligible to access resources designated for "homeless veterans."

I approached Chairman Benishek with my legislation—H.R. 627, which updates the definition of "homeless veteran" to include victims fleeing domestic violence, not only was he extremely supportive of it, he joined me in introducing it. For that, I thank you Mr. Chairman.

Our legislation will update the definition of homeless veteran to include veterans fleeing domestic violence, and will correct this oversight and ensure that veterans fleeing domestic violence can receive benefits from the VA.

This is a minor change of great importance to ensure veterans do not feel trapped in dangerous situations.

H.R. 627 is endorsed by countless veterans organizations, such as Veterans of Foreign Wars (VFW), AMVETS, The National Coalition for Homeless Veterans, The Service Women's Action Network, Blinded Veterans Association, and the list goes on and on.

Providing benefits to veterans driven to homelessness by domestic violence is something we all should support—and have supported in the past.

In fact, I have worked with the House Appropriations Veterans Affairs Subcommittee to include report language the past two years to make these benefits available. That process, however, only helps until the next year and has to be repeated every year to provide temporary help.

Now is the time to stop making temporary fixes. This legislation permanently fixes this loophole for veterans.

While it is unknown how many veterans will be helped by this bill, if it provides one veteran the support they need to leave a dangerous situation, our work here will be worth every minute.

We must step up to provide these heroes who have protected us with the resources they need including a place where they can be safe and protected.

In conclusion, I want to thank you for working with me to solve an urgent problem, and I yield back the balance of my time.

PREPARED STATEMENT THE HON. JACKIE WALORSKI

Good morning Chairman Benishek, Ranking Member Brownley, and members of the Committee. Thank you for the opportunity to discuss H.R. 1369, the Veterans Access to Extended Care Act. This important bill will allow the Department of Veterans Affairs (VA) to enter into provider agreements for extended care services.

VA offers a variety of long-term services and supports to veterans in the form of nursing home care, adult day care, respite care, domiciliary services, hospice and palliative care. Care is provided through VA medical centers, State Veterans Homes, or other community organizations. Currently, non-VA providers at community organizations must contract with the VA to provide these kinds of services. Under the Service Contract Act (SCA), these community providers are considered federal contractors, a designation that imposes burdensome reporting requirements relating to the demographics of contractor employees and applicants, ultimately discouraging numerous providers from entering into contracts with the VA. For these organizations, reimbursement from the VA for caring for veterans is simply not worth the cost of compiling and reporting the data required by general federal contract law. This situation has left many veterans and their families without the ability to find providers close to their homes.

On February 13, 2013, the VA released proposed rule, RIN 2900–A015, which would have increased access to these non-VA extended care services from local providers,[1] by permitting these providers to enter into agreements with the VA under the same guidelines that providers for Medicare enter into agreements with the Centers for Medicare & Medicaid Services (CMS). This means that non-VA providers would no longer be considered federal contractors. Non-VA providers would still have to comply with all federal hiring laws, but they would be relieved from the burdensome reporting requirements.

In conjunction with a Senate letter that was sent in June of 2014, Congresswoman Tulsi Gabbard and I, along with 107 of our colleagues in the House sent a letter in August of 2014 to Secretary McDonald encouraging the release of the final VA provider agreement rule. Unfortunately, despite the willingness of the Department, the VA never had the legislative authority to begin with to enact this rule.

[1] Use of Medicare Procedures To Enter Into Provider Agreements for Extended Care Services, Proposed Rule: RIN 2900–AO15. Federal Register Vol. 78, No. 30 (February 13, 2013).

In response, Representative Gabbard and I introduced H.R. 1369, Veterans Access to Extended Care Act. This commonsense bill gives the VA the legislative authority it needs to follow through with the original proposed rule. Specifically, this bill amends subparagraph (B) of section 1720(c) (1) of Title 38 of the U.S. Code by adding an exemption for extended care service providers from being treated as federal contractors for the acquisition of goods or services. The bill also modifies section 6702(b) of Title 41 of the U.S. Code, which relieves providers from certain reporting requirements to the Department of Labor. Lastly, it includes quality assurance provisions to ensure the safety and a high standard of care our veterans deserve. Should a provider fail to comply with a provision of the agreement, VA has the authority to terminate the agreement.

Eliminating this contractor designation will encourage more extended care service providers to enter into agreements, which will provide veterans with more options in the community. Incentivizing more local providers to work with the VA will increase access to care that is closer to home allowing nearby family and friends to provide an additional support structures to our veterans. The family structure during these times is a vital part of ensuring a veteran's quality of life. These individuals have sacrificed so much in the name of liberty; they should not have to worry about being unable to find care close to home because their hometown providers do not have the resources necessary to qualify as a government contractor. Eliminating this designation will encourage more extended care service providers to enter into agreements, which will provide veterans with more options in the community that will allow their family, friends to provide an additional support structure for them. Providing veterans with the care they need and deserve continues to be a top priority of mine and every member of this committee. I am grateful to work with Representative Gabbard, Senator Hoeven, Senator Manchin, and the Committee in addressing this critical issue for veterans. I thank you again for this opportunity to speak today.

STATEMENT OF BLAKE ORTNER
DEPUTY GOVERNMENT RELATIONS DIRECTOR
PARALYZED VETERANS OF AMERICA
PROVIDED TO THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
CONCERNING PENDING LEGISLATION

APRIL 23, 2015

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Subcommittee. No group of veterans understand the full scope of care provided by the VA better than PVA's members—veterans who have incurred a spinal cord injury or dysfunction. Most PVA members depend on VA for 100% of their care and are the most vulnerable when access to health care, and other challenges, impact quality of care. These important bills will help ensure that veterans receive timely, quality health care and benefits services.

Draft legislation: Reproductive Services for Disabled Veterans

PVA supports the draft legislation to provide assisted reproductive technology (ART), such as in-vitro fertilization (IVF) to certain disabled veterans. For many disabled veterans, one of the most devastating results of spinal cord injury or dysfunction is the loss of, or compromised ability, to have a child. As a result of the recent conflicts in Afghanistan and Iraq, many service members have incurred injuries from explosive devices that have made them unable to conceive a child naturally. While the Department of Defense does provide ART to service members and retired service members, VA does not. When a veteran has a loss of reproductive ability due to a service-connected injury, they must bear the total cost for any medical services should they attempt to have children. It is often the case that veterans cannot afford these services and are unable to receive the medical treatment necessary for them to conceive. For many paralyzed veterans procreative services have been secured in the private sector at great financial and personal cost to the veteran and family.

Procreative services, provided through VA, would ensure that certain disabled veterans are able to have a full quality of life that would otherwise be denied to them as a result of their service. For more than a decade, improvements in medical treatments have made it possible to overcome infertility and reproductive disabilities, and veterans who have a loss of reproductive ability as a result of a service-connected injury should have access to these advancements.

The bill would also offer veterans the option of cryopreservation of genetic material for three years. This empowers veterans to protect their viability to have a family should they undergo medical treatments that would be hazardous to a pregnancy or take medications that could affect the quality of genetic materials. These are invaluable services that will overwhelmingly improve the well-being of our veterans.

While PVA strongly supports this draft legislation, we note that it is limited in addressing the needs of women veterans. Some women veterans with a catastrophic injury may be able to conceive through IVF but be unable to carry a pregnancy to term due to their

disability. In such an instance implantation of a surrogate may be their only option. The current draft of the bill is not inclusive of all women veterans with a catastrophic reproductive injury.

Further, we believe clarification is necessary where the draft prohibits "any benefits relating to surrogacy or third-party genetic material donation." For veterans who have sustained a blast injury or a toxic exposure that has destroyed their "genetic material," a third-party donation may be the only option. For example, if a veteran loses his testicles in a blast injury, would a family friend be permitted to donate sperm for an IVF cycle with the veteran's wife's eggs? Would VA be unable to conduct the fertilization unless the genetic material was from the veteran? We believe these types of questions must be addressed before the legislation is advanced.

Draft legislation: Annual VHA Report

PVA generally supports this draft legislation. The bill would require a yearly evaluation of overall effectiveness of the Veterans Health Administration (VHA) in improving access to care and the quality of it. The report would require an assessment of physician and employee workload, patient demographics and utilization rates, physician compensation, percentages of care provided in VA facilities, and pharmaceutical prices.

PVA believes it is critical that VHA be required to assess the services it provides continuously. The information relayed is also imperative for the function of Congress in its oversight responsibilities. However, during the Subcommittee on Health hearing held on January 28, 2015, Deputy Under Secretary for Health Dr. Tuchschmidt spoke on VA's existing ability to conduct statistical analyses on some of the assessment requirements outlined in this bill. He commented further on VA's goal to make VHA data more readily accessible. Is this bill intended to mandate what the VA committed to doing during the hearing on January 28?

In order to improve this bill, PVA strongly encourages adding language to reinstate the reporting requirement on the capacity of VHA to provide specialized services to disabled

veterans. The VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans—veterans with spinal cord injury/disease, blindness, amputations and mental illness—as mandated by P.L. 104-262, the "Veterans' Health Care Eligibility Reform Act of 1996." This law requires VA to maintain its capacity to provide for the special treatment and rehabilitative needs of catastrophically disabled veterans.

As a result of P.L. 104-262, the VA developed policy that required the baseline of capacity for VA's Spinal Cord Injury/Disease (SCI/D) system of care to be measured by the number of staffed beds and the number of full-time equivalent employees assigned to provide care. Under this law, the VA was also required to provide Congress with an annual "capacity" report. This reporting requirement expired in 2008.

Currently, within the SCI/D system of care, the VA is not meeting capacity requirements for staffing and the number of inpatient beds that must be available for SCI/D veterans. Reductions of both inpatient beds and staff in VA's acute and extended care settings have been consistently reported throughout the SCI/D system. VA has eliminated staffing positions that are necessary for an SCI/D center or clinic to maintain its mandated capacity to provide care, or operated with vacant health care positions for prolonged periods of time. When this occurs, veterans' access to VA decreases, remaining staff become overwhelmed with increased responsibilities, and the overall quality of health care is compromised.

As a component of workforce planning, VA tracks the status of vacant and staffed health care positions throughout the Veterans Health Administration. They also track the number of veterans utilizing health care within the specialized systems of care. With this information readily available, VA is able to compile and use the collected data for annual reports and assess its ability to meet the capacity mandate.

The "Toxic Exposure Research Act of 2015"

PVA understands the intent of and generally supports this legislation. This bill would require the VA Secretary to select one VA medical center to serve as the national center for research on the diagnosis and treatment of health conditions of descendents of individuals exposed to toxic substances while serving in the Armed Forces. It would also require the establishment of an advisory board for the national center to determine links between exposure and health conditions. However, the bill does not discuss the processes should the advisory board conflict with the findings of the IOM. We encourage the Subcommittee and VA to work together to ensure the legislation fulfills the IOM Committee recommendations.

H.R. 271, the "Creating Options for Veterans Expedited Recovery Act"

PVA generally supports H.R. 271, the "Creating Options for Veterans Expedited Recovery Act." This legislation would establish a commission to examine VA's current mental health therapy model and the potential benefits of incorporating complementary alternative therapies. The bill aims to fill in the needs gaps for those who are not effectively served by traditional, evidence-based treatment plans. PVA believes that effective medical care, traditional or alternative, ought to be readily available to a veteran in need. Therapies for the commission to evaluate range from outdoor sports therapy, to accelerated resolution therapy, to equine therapy. These options fall outside VA's typical services. It is PVA's position that all VA mental health care should meet the specific, individual need of the veteran seeking medical services, on a consistent basis. Complementary and alternative medicines give veterans with mental illness, as well as catastrophic disabilities, additional treatment options. This commission could offer an opportunity to identify additional "best practices" across medical disciplines.

H.R. 627

H.R. 627 would expand the VA's definition of "homeless" to match the definition used by the Department of Housing and Urban Development (HUD) since 1987. Domestic violence is just as much a public health matter as homelessness, and for women veterans it is a major cause. Thirty-nine percent of women veterans report experiencing

domestic violence, well above the national average. As a result of definitions outlined in title 38, U.S.C., Section 2002(1), these veterans are not eligible to access resources for homeless veterans. These heroes, who have protected us, and endured violence in their own home, are told by their government they are not worth protecting. The basic expectations for the human condition, of safety from violence and shelter, are denied to the very people who ensured it for us. What does it say to these men and women, about the value of their service and the value of them as people, when the VA explains that the way in which they experience homelessness is not as critical as for those covered under the existing definition?

For a mother with a teenage son, she will be less likely to leave the abusive household, as most women's shelters do not allow teenage male children. In order to not leave her child she will continue to endure violence as she has nowhere else to go. This problem is even more pronounced for rural veterans, as traveling anywhere is costly. With small children it is all the more complicated.

No veteran should have to choose between enduring violence and homelessness. And without change that is what they are forced to continue to do. Congress is obligated to keep these veterans safe.

H.R. 1369, the "Veterans Access to Extended Care Act of 2015"

PVA generally supports H.R. 1369, the "Veterans Access to Extended Care Act of 2015." This bill would modify the treatment of VA agreements with service providers to furnish extended care services, also known as Long-Term Services and Supports (LTSS). LTSS cover the range of medical and personal care assistance that a veteran may need when completing daily tasks (eating, bathing, managing medication). These VA services are often received by veterans in their home or in an institutional setting.

H.R. 1369 would allow veterans to obtain non-VA LTSS from local providers that include nursing center care, geriatric evaluation, domiciliary services, adult day health care, respite care, palliative care, hospice care, and home health care when there are "non-

institutional alternatives to nursing home care." The bill would also allow LTSS providers to enter into VA Provider Agreements, rather than contracting with VA, thereby avoiding the complex processes required under the Service Contract Act. The bill also includes VA review requirements of provider licensing and facilities.

H.R. 1575

PVA supports H.R. 1575, a bill to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces. The bill would provide VA with the authority to extend the program using the same measurements and eligibility requirements.

The program, managed by the Readjustment Counseling Service, has been a marked success. For two years, VHA offered six week-long retreats in California, Colorado, New Mexico and Connecticut. Eighty-five percent of the 134 veterans showed improvements in psychological wellbeing. Other long lasting improvements included decreased stress symptoms and increased coping skills. It is essential for women veterans that Congress reauthorize this program. We believe the value and efficacy is undeniable.

PVA would once again like to thank the Subcommittee for the opportunity to submit our views on the legislation considered today. Enactment of much of the proposed legislation will significantly enhance the health care services available to veterans, service members, and their families. I would be happy to answer any questions that you may have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2015

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $425,000.

Fiscal Year 2014

No federal grants or contracts received.

Fiscal Year 2013

National Council on Disability — Contract for Services — $35,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

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Blake Ortner is the Deputy Government Relations Director with Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for federal legislation and government relations, as well as veterans' budget, benefits and appropriations analysis. He has represented PVA to federal agencies including the Department of Labor, Office of Personnel Management, Department of Defense, HUD and the VA. In addition, he is PVA's representative on issues such as Gulf War Illness and he coordinates issues with other Veteran Service Organizations.

He has served as the Chair for the Subcommittee on Disabled Veterans (SODV) of the President's Committee on the Employment of People with Disabilities (PCEPD) and was a member of the Department of Labor's Advisory Committee on Veterans' Employment and Training (VETS) and the Veterans Organizations Homeless Council (VOHC).

A native of Moorhead, Minnesota, he attended the University of Minnesota in Minneapolis on an Army Reserve Officer Training Corps (ROTC) scholarship. He graduated in 1983 with an International Relations degree and was commissioned as a Regular Army Infantry Second Lieutenant. He was stationed at Ft. Lewis, WA, where he served with the 9th Infantry Division and the Army's elite 2nd Ranger Battalion. He left active duty in September 1987.

He continues his military service as a Brigadier General in the Virginia Army National Guard and is a 2010 graduate of the US Army War College. From 2001-2002, he served as Chief of Operations - Multi-National Division North for peacekeeping missions in Bosnia-Herzegovina, from 2004-2005 he commanded an Infantry Battalion Task Force in Afghanistan earning 2 Bronze Star Medals, from 2007 to 2008 he served in Iraq as the Chief of Operations - Multi-National Force – Iraq earning a Bronze Star Medal and a Joint Commendation Medal, and from 2011-2012 he commanded a NATO Infantry Brigade Combined Combat Team in Afghanistan earning a Bronze Star Medal and Meritorious Unit Citation. Additional awards include the Legion of Merit, the Combat Infantryman Badge, Combat Action Badge, Ranger Tab, Military Free Fall Parachutist Badge and the Parachutist Badge. He currently serves as the Assistant Division Commander of the 29th Infantry Division for the Virginia Army National Guard.

Mr. Ortner resides in Stafford, VA with his wife Kristen, daughter Erika and son Alexander.

STATEMENT OF
LOUIS J. CELLI, JR., DIRECTOR,
NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION,
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
PENDING LEGISLATION

APRIL 23, 2015

Chairman Benishek, Ranking Member Brownley, and distinguished members of the subcommittee, On behalf of our National Commander, Michael Helm, and the 2.3 million members of The American Legion, we thank you for this opportunity to testify regarding The American Legion's positions on pending legislation before this subcommittee.

Draft bill

To amend title 38, United States Code, to improve the reproductive treatment provided to certain disabled veterans

As a result of more than a decade of war, thousands of male and female service members are returning home with physical and/or psychological wounds of the war resulting in a variety of fertility and reproductive health issues. Many young servicemembers have been documented with low testosterone levels that can be attributed to the medications that they are taking for their physical injuries, and conditions such as traumatic brain injury (TBI) or posttraumatic stress disorder (PTSD), as well as the poisonous effects of environmental exposures they have faced while serving on active duty.

Currently, the Department of Defense (DOD) and Department of Veterans Affairs (VA) offer servicemembers and veterans some form of fertility and reproductive treatment and counseling. However, the servicemembers and veterans who choose to start a family but struggle with fertility issues as a result of their injuries will, in many cases face paying tens of thousands of dollars out of pocket for treatments and services that are not paid for by the DOD or VA. Some fertility treatments can be extremely costly. Veterans currently cannot receive many of these services from VA.

The DOD and VA need to put emphasis on creating solutions for those who have lost anatomical parts required to participate in the physical act, but there seems to be little support either through counseling or medical intervention to offer young veterans who has lost his/her ability to procreate due to lack of testosterone. Unfortunately, many veterans with TBI are also on hypertension medications, and adding sexual performance medications can represent a serious health risk. This can also create a loss of intimacy in relationships, exacerbating psychological

disorders such as PTSD and depression. Ultimately, it affects the self-esteem of both veteran and spouse.

The American Legion urges Congress and the Department of Defense to support and fund quality of life features including, but not limited to adequate medical, mental health, and morale services as well as for Congress to extend and improve additional quality of life benefits to servicemembers and dependents who have been injured while serving on active duty.[1]

The American Legion supports this legislation.

Draft bill

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to submit an annual report on the Veterans Health Administration and the furnishing of hospital care, medical services, and nursing home care by the Department of Veterans Affairs.

In December 2014, the Congressional Budget Office (CBO) published a report *Comparing the Cost of the Veterans' Health Care System with Private-Sector Costs*. This report attempts to assess the question if health care for veterans provided through the Veterans Health Administration (VHA) is less expensive than receiving health care from private health care providers in the community. The CBO report states that based upon the currently available data and research, there is *"limited evidence and substantial uncertainty"* about the relative costs between the VA health care and private health care that veterans receive.

The CBO notes one barrier to making clear comparisons between the VHA and the private sector: Unlike many government agencies, the VHA doesn't publish the necessary data. "Comparing health care costs in the VHA system and the private sector is difficult partly because the Department of Veterans Affairs (VA), which runs VHA, has provided limited data to the Congress and the public about its costs and operational performance," the report states.

The Department of Defense (DOD) publishes each fiscal year an annual report that is submitted to Congress that evaluates the TRICARE Healthcare Program. This report evaluates access, cost, and quality of the DOD healthcare system. A corresponding annual report from the VA on how the department spends on veteran's health care may allow for clearer comparisons between VHA care and the private sector. It should be noted, though, that the CBO report says "such comparisons would still be challenging, in part, because private-sector data might also be incomplete, unavailable, or difficult to make comparable with VHA data." [2]

Still, The American Legion has urged comprehensive study of the VA healthcare system, to include the purpose, goals, objectives, budget and evaluation of effectiveness of the 21 Veteran

[1] American Legion Resolution No. 182: *"Support for Military Quality of Life"* http://archive.legion.org/bitstream/handle/123456789/3540/2014N182.pdf?sequence=1

[2] Congressional Budget Office, Dec. 2014, page 2, *"Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs"*: https://www.cbo.gov/sites/default/files/cbofiles/attachments/49763-VA_Healthcare_Costs.pdf

Integrated Service Networks.[3] Only with a transparent evaluation of VHA operations can the effectiveness of the delivery of care be properly evaluated.

The American Legion supports this draft bill

H.R.271: The COVER Act

To establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

According to a study by the RAND corporation, of the more than 1.64 million troops deployed as part of Operation Enduring Freedom (OEF, Afghanistan) and Operation Iraqi Freedom (OIF, Iraq) since October 2001, approximately 26 percent of the returning troops may be suffering from mental health disorders, with the frequency of diagnoses increasing even as the rates for other medical diagnoses remained constant.[4] In addition, there is also a distressingly high rate of suicide among veterans and active duty service members.

The Creating Our Veterans Expedited Recovery Act (COVER) would establish a commission to explore the possibility of incorporating complementary and alternative medicine (CAM) treatment models into Department of Veterans' Affairs (VA) medical facilities nationwide. This piece of legislation would increase the viable options of alternative treatments and therapies that are offered to veterans for the purpose of treating their mental health conditions and physical disabilities as a result of their military service.

This legislation would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

As a result of The American Legion's deep concerns with the numbers of veterans returning home from the wars in Iraq and Afghanistan who are suffering from TBI and PTSD, which are often referred to as the *"signature wounds"* of the war on terror, The American Legion in October 2010, formed a Post Traumatic Stress Disorder/Traumatic Brain Injury Ad Hoc Committee, to *"investigate the existing science and medical procedures, as well as alternative methods, for treating TBI and PTSD currently being employed by the Department of Defense or the Department of Veterans Affairs."*

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[3] Resolution No. 114: *Department of Veterans Affairs Veteran Integrated Service Networks* – AUG 2014: http://archive.legion.org/bitstream/handle/123456789/3754/2014N114.pdf?sequence=1&isAllowed=y

[4] RAND Study: *Invisible Wounds of War Summary and Recommendations for Addressing Psychological and Cognitive Injuries* – 2008: http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.1.pdf

In September 2013, The American Legion released a report titled *"The War Within"* which included findings and recommendations based on comprehensive research by The American Legion's PTSD/TBI Ad Hoc Committee. The key findings from the report include:

- VA and DOD having no well-defined approach to the treatment of TBI
- Providers are merely treating the symptoms
- DOD and VA research studies are lacking for new non-pharmacological treatments and therapies such as virtual reality therapy, hyperbaric oxygen treatment, and other complementary and alternative medicine therapies.

The report recommended that Congress increase DOD and VA budgets to improve the research, screening, diagnosis, and treatment of TBI and PTSD, as well as accelerate their research efforts to properly diagnose and develop evidence-based treatments for TBI and PTSD.[5]

In February 2014, The American Legion conducted a TBI and PTSD veteran survey to evaluate the efficacy of their TBI and PTSD medical care and to see if veterans who are suffering from these signature wounds are being offered complementary and alternative treatments and therapies and if they are, whether they are benefiting from such treatments and therapies. Of the 3,116 veterans who completed the survey, which focused on four key areas:

- Types of treatments veterans received
- Access and availability of CAM therapies
- Perceived benefits of treatments, and
- Reasons for terminating treatments

The survey highlighted that fifty-nine percent reported either feeling no improvements or feeling worse after undergoing treatments for their TBI and PTSD symptoms, thirty percent have terminated their treatments and therapies prior to completing them, as well veterans reporting that they are taking up to ten different medications for their PTSD and TBI symptoms. The reasons were:

- Patients were unwilling or unable to comply with the treatments,
- Patients were unmotivated to participate in their treatment, and
- Patients expressed distress associated with recounting trauma which initially resulted in worsening symptoms which eventually led to premature termination.[6]

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[5] *The American Legion's War Within Report:* http://legion.org/documents/legion/pdf/american-legion-war-within.pdf

[6] *The American Legion Survey of Patient Healthcare Experiences:* http://www.legion.org/veteranshealthcare/222891/legion-survey-ptsdtbi-care-not-working

In June 2014, The American Legion, along with Military.com, sponsored a TBI and PTSD symposium titled, *"Advancing the Care and Treatments for Veterans with TBI and PTSD."* The symposium was held to examine how Congress, DOD, and VA are integrating CAM treatments and therapies into the existing health care models for veterans with TBI and PTSD. This symposium enabled the disparate groups in the government and private sector to align themselves on the same page and share information about successful treatment models including canine therapy, working with service members prior to and during deployments to increase resiliency, as well as other treatment options. The American Legion continues to work with public and private sector resources to study positive treatment options for veterans struggling with TBI and PTSD.

With veteran suicide rates unacceptably high, veterans need innovative approaches to address these "signature wounds" of the War on Terror, as well as for veterans of all eras who struggle with these disorders. H.R. 271 would increase the viable options of CAM offered to veterans for the purpose of treating their mental health conditions and physical disabilities. The American Legion urges Congress to act to provide oversight and funding to DOD and VA for innovative TBI and PTSD research currently being used in the private sector to include non-pharmacological treatments.[7]

The American Legion supports H.R. 271

H.R. 627

To amend title 38, United States Code, to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs.

Of the total homeless adult population, 11 percent are veterans and 10 percent of those veterans are women. Over 74,000 homeless veterans have been served through the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD/VASH) program. Seeing the need for assistance, The American Legion has taken a leadership role within local communities by volunteering, fundraising, advocating for programs and funding for homeless veterans. Nationally, The American Legion is assisting with the veteran homeless crisis by providing housing in areas such as Connecticut and Pennsylvania.

The American Legion strongly believes that homeless veteran programs should be granted sufficient funding to provide supportive services such as, but not limited to, outreach, healthcare, rehabilitation, case management, personal finance planning, transportation, vocational counseling, employment and training, as well as education. The American Legion restates our commitment to assisting homeless veterans and their families and supports any legislative or administrative proposal that will provide medical, rehabilitative and employment assistance to

[7] Resolution 292: Traumatic Brain Injury and Posttraumatic Stress Disorder Programs: http://archive.legion.org/bitstream/handle/123456789/3614/2014N292.pdf?sequence=1&isAllowed=y

homeless veterans and their families. Therefore, we fully support enacting H.R. 627, and applaud your leadership in addressing this critical issue facing our nation's veterans.[8]

The American Legion supports H.R. 627 because it adds domestic violence and other dangerous or life threatening conditions to the VA's definition of homelessness, which would allow veterans or families of veterans in this situation to qualify as homeless for the purposes of VA programs. We believe this legislation would be profoundly beneficial as it works alongside VA's goal of eliminating veteran homelessness by the end of 2015.

The American Legion supports this bill

H.R. 1369: Veterans Access to Extended Care Act of 2015

To modify the treatment of agreements entered into by the Secretary of Veterans Affairs to furnish nursing home care, adult day health care, or other extended care services, and for other purposes.

H.R. 1369 would give the Department of Veterans Affairs (VA) the authority to enter into provider agreements for extended care services. The legislation would permit veterans to obtain non-VA extended care services from local providers that include: nursing center care, geriatric evaluation, domiciliary services, adult day health care, respite care, palliative care, hospice care, and home health care when they are *"non-institutional alternatives to nursing home care."*

According to Department of Veterans Affairs 38 Code Federal Regulations (CFR) Part 17 proposed rule 2900–AO15 published in February 2013 entitled, *"Use of Medicare Procedures To Enter Into Provider Agreements for Extended Care Services"* allows the Department of Veterans Affairs (VA) to use Medicare or State procedures to enter into provider agreements to obtain extended care services from Non-VA providers to include home health care, palliative care, non institutional hospice as well as extended care services when offered as an alternative to nursing home care. Under this rule VA would also be able to obtain extended care services from providers that are closer to where the veteran resides.[9]

H.R. 1369 would exempt agreements entered into by the Secretary of Veterans Affairs for nursing home care, adult day health, or other extended care services under section 1720 of title 38 by amending section 6702(b) of title 41, United States Code.

On March 9, 2015, a letter was referred to The American Legion's Veterans Affairs and Rehabilitation Division from a veterans' brother in Indianapolis, Indiana concerning veterans who are residing at the Madonna Rehabilitation Hospital in Lincoln, Nebraska at VA's expense. According to the writer, the Madonna Rehabilitation Hospital will no longer be able to provide

[8] Resolution 306: *"Funding for Homeless Veterans"*:
http://archive.legion.org/bitstream/handle/123456789/3629/2014N306.pdf?sequence=1

[9] Department of Veterans Affairs 38 CFR Part 17:
http://www.va.gov/orpm/docs/20130213_A015_UseofMedicareProceduresToEnter.pdf

care to veterans at VA expense because of a law that was passed requiring a federal contract. The letter stated the Madonna has always operated under a provider agreement with the VA. To understand the writers concerns, The American legion's Veterans Affairs and Rehabilitation staff contacted the staff in the VHA Office of Geriatrics and Extended Care, to see if they could shed light on this issue. According to Dan Schoeps, Director, VHA Purchased Long-Term Services he informed us that VA is aware of this issue. Under VA's policies, VA has two methods of purchasing Non-VA Nursing home care, by contracts or by Blanket Purchasing Agreements (BPAs). Some nursing homes do not want to enter into a formal contact with the VA, which is why BPA's are used in lieu of formal contracts. In the Madonna Rehabilitation Hospital case, VA Central Office staffed informed our office that the acting VISN 23 Director temporarily extended the BPA currently in place until April 2015. If the agreements are allowed to lapse, many veterans may have to be displaced.

If this bill is not enacted into law, VA will no longer be able to have BPA agreements with Nursing homes, which may result in many nursing homes no longer accepting veterans into the facility for nursing home care, adult day health care, or other extended care services. The American Legion vigorously opposes the dilution of the benefits veterans have earned with their service and sacrifice.[10]

American Legion supports this bill

H.R. 1575

To amend title 38, United States Code, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

On January 1, 2016, the Secretary shall carry out, through the Readjustment Counseling Services (RCS), a program to provide reintegration and readjustment services in group retreat settings to women veterans who are recently separated from services in the Armed Forces after a prolong deployment. The participation of a veteran in the program shall be at the election of the veteran.

H.R 1575 is the result of a report released by the Veterans' Health administration (VHA) showing that the two-year pilot program under the jurisdiction of the VA Readjustment Counseling Service (RCS) has significantly assisted returning women veterans who have post traumatic stress disorder as a result of their combat service. This bill provides the VA with permanent authority to extend the program using the same criteria when the program was first established.

The American Legion supports the establishment of a women veterans' awareness training program that educates employees about the changing roles of women in the military, their

[10] Resolution No. 18: *Department of Veterans Affairs Disability Compensation* – AUG 2014: http://archive.legion.org/bitstream/handle/123456789/3524/2014N018.pdf?sequence=1&isAllowed=y

combat exposures and military sexual trauma sensitivity as well as to ensure that the needs of the current and future women veteran populations are met. [11]

The American Legion supports this legislation.

H.R. 1769: Toxic Exposure Research Act Of 2015

To establish in the Department of Veterans Affairs a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces that are related to that exposure, to establish an advisory board on such health conditions, and for other purposes.

The effects of the often dangerous environments in which service members operate is a top concern of The American Legion, as thousands of veterans who are or have been exposed to various toxins are often left behind when it comes to vital treatments and benefits. The American Legion remains committed to ensuring that all veterans who served in areas of exposure receive recognition and treatment for conditions linked to environmental exposures.

This legislation requires the Department of Veterans Affairs (VA) to establish a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans that are exposed to toxic substances during their military service, as well as an advisory board on exposure to toxic substances.

The American Legion has long been at the forefront of advocacy for veterans who have been exposed to environmental hazards such as Agent Orange, Gulf War-related hazards, ionizing radiation, the various chemicals and agents used during Project Shipboard Hazard and Defense (SHAD), and contaminated groundwater at Camp Lejeune. The American Legion continues to urge the study of all environmental hazards and their long-term effects they have on our servicemembers, veterans, and their families.

The American Legion has also called on the Department of Defense to immediately cease burning dangerous chemicals in open burn pits, exposing servicemembers to deadly and debilitating toxins.[12]

The American Legion believes in treating the veteran first, funding the necessary research, and ensuring that servicemembers are not exposed to chemical hazards again. This legislation would help address the need to better understand the toxins that many of veterans have been exposed to, and enhance the understanding that the effect of exposure may have on veterans' descendants.

The American Legion supports this bill

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[11] Resolution 45: *" Women Veterans"*
http://archive.legion.org/bitstream/handle/123456789/2305/2012F045.pdf?sequence=1

[12] Resolution 125: Environmental Exposures:
http://archive.legion.org/bitstream/handle/123456789/3759/2014N125.pdf?sequence=1

Conclusion

As always, The American Legion thanks this subcommittee for the opportunity to explain the position of the 2.3 million veteran members of this organization.

For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division at (202) 861-2700 or wgoldstein@legion.org.

Executive Summary

The American Legion supports the following draft bills:

- To amend title 38, United States Code, to improve the reproductive treatment provided to certain disabled veterans
- To amend title 38, United States Code, to direct the Secretary of Veterans affairs to submit an annual report on the Veterans Health Administration and the furnishing of hospital care, medical services, and nursing home care by the Department of Veterans Affairs

The American Legion supports the following bills:

- H.R. 271: The Cover Act
- H.R. 627: To amend title 38, United States Code, to expand the definition of homeless veteran
- H.R. 1369: Veterans Access to Extended Care Act of 2015
- H.R. 1575: To amend title 38, United States Code, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces
- H.R. 1769: Toxic Exposure Research Act of 2015

VIETNAM VETERANS of AMERICA

Submitted By

John Rowan
National President

Before the

Subcommittee on Health of the
House Veterans' Affairs Committee

Regarding

Legislation to improve reproductive treatment for certain disabled veterans;
Veterans Health Administration Annual Reports;
H.R. 1769, the "Toxic Exposure Research Act of 2015";
H.R. 271, the COVER Act;
H.R. 627, to expand the definition of Homeless Veterans;
H.R. 1369, the "Veterans Access to Extended Care Act of 2015"; and
H.R. 1575, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service.

April 23, 2015

Mr. Chairman, Ranking Member Brownley, and other distinguished members of this subcommittee, Vietnam Veterans of America (VVA) appreciates the opportunity to present our views on some very significant pending legislation.

Draft legislation, introduced by Congressman Jeff Miller (FL-1), would improve the reproductive treatment provided to certain disabled veterans,

VVA strongly favors the passage of this legislation at an early date. There is nothing that is of greater concern to many recent veterans and their families – and the families they hope to have.

Draft legislation, introduced by Congressman Dan Benishek, (MI-01), would amend title 38, US Code to direct the Secretary of Veterans Affairs to submit an annual report on the Veterans Health Administration (VHA) and the furnishing of hospital care, medical services, and nursing home care.

VVA believes that this is one more useful step in the common quest of the Congress and the veterans service organizations to ensure that the VHA is held fully accountable for performance of the central mission of this veterans health organization: to deliver the very best health care, as a timely and efficient matter of course, to eligible veterans.

H.R.1769 the **"Toxic Exposure Research Act of 2015,"** introduced by Congressman Dan Benishek, (MI-01) with original co-sponsors Representatives Mike Honda and Elizabeth Esty, would establish a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during their time in the Armed Forces; and it also would establish an advisory board on exposure to toxic substances.

Vietnam Veterans of America applauds the leadership of Congressman Benishek, in working with his colleague, Congressman Mike Honda, to construct and introduce this bipartisan bill. Among the invisible wounds of war are those brought home by troops that may not manifest for a decades. Most tragically, they may also pass on genetically the effects of these wounds to their progeny. No one can argue that our children and grandchildren should have these burdens visited on them.

This is a multi-generational bill. It provides a common vehicle for evaluating potential effects toxic exposures, from Camp Lejeune and Fort McClellan to Agent Orange in multiple locations to the toxic plume that sickened thousands of Gulf War veterans.

Toxins, such as TCDD dioxin, are believed to cause birth defects in children of military personnel who came into contact with them – in-country troops during the Vietnam War, particularly in troops involved in the the storage and transportation of those toxins; the several thousand Reservists who rode in and maintained aircraft that had been used to transport the toxins. For Gulf War veterans, the exposure was to chemical weapons in an Iraqi ammo dump that was blown up by U.S. Forces at the end of the Gulf War; and burn

pit smoke and possibly tainted vaccines and medicines ingested by troops in Afghanistan and Iraq.

This is a simple and straightforward proposal that will begin to address the needs of the progeny of every generation of veterans, because the health conditions seen in some are so heartbreaking to so many families who wonder: Did my service cause my child[ren] to suffer? (Please see "Faces of Agent Orange" at https://www.facebook.com/pages/Faces-of-Agent-Orange/187669911280144)

VVA is grateful to the Chairman for introducing this vitally needed legislation that will help ensure that the possible effects of toxins on our progeny, and those of every generation of veterans, are properly addressed and assisted.

H.R. 271, the **COVER** (Creating Options for Veterans Expedited Recovery Act), introduced by **Congressman Gus Bilirakis (FL-12),** would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses in veterans and the potential benefits of incorporating complementary alternative treatments available in non-VA medical facilities in the community.

VVA is aware that many Complementary and Alternative Medicines, or CAM, treatments are being actively promoted as effective "cures" for PTSD – without adequate, rigorous research data to support these claims. In the words of the pre-eminent PTSD researcher, Dr. Charles W. Hoge, Col., U.S. Army (Ret.), "Obviously it's a lot easier to just claim that a treatment is effective without doing the research, which is why there's a glut of snake oil salesmen in this business now." Currently, effective treatments for PTSD already exist and are well-detailed in the Institute of Medicine (IOM) report, DoD/VA Evidence-based Clinical Guidelines for PTSD.

Thus, H.R. 271's focus on examining the effectiveness of CAM, such as music therapy, equine therapy, pet therapy, yoga, acupuncture, meditation, outdoor experiential therapy (sports), hyperbaric oxygen therapy, accelerated resolution therapy (or ART), and a host of other treatment modalities that include dietary and/or herbal supplements, highlights the need for high-quality research of all new PTSD treatments, especially as new treatments seem to spring up daily and are touted as the latest "silver bullet" for PTSD (and m-TBI) for returning combat veterans. Some of these treatments have been widely advertised through media news stories, leaving many veterans and their families wondering why the VA (or DoD) has not adopted them yet.

Therefore, although VVA supports the intent of H.R. 271, and salutes Congressman Bilirakis for his continued strong advocacy on behalf of veterans, we advocate instead **the creation of a ten-member commission to review the scientific, research evidence base for all such CAM treatments**, so that sometimes ill-founded marketing claims can be punctured as the reason why VA (or DoD) have not adopted a particular CAM. VVA suggests one condition to such a commission's membership appointment criteria (Section 3): appointees ***must not*** have a proprietary interest (financial or otherwise) in any of the

CAM treatments that are reviewed under its jurisdiction. (See also VVA statement of Feb. 19, 2014 before the HVAC Subcommittee on Health.)

VVA agrees with Mr. Bilirakis that some of these therapies may be useful, and urges that VA be required to do clinical trials to amass the evidence one way or another. If it is worth doing, then it is worth doing clinical trials on these therapies that have promise. Our veterans deserve the very best ***evidence-based medicine***.

H.R. 627, introduced by Congresswoman Janice Hahn (CA-44), would amend title 38 of the US Code to expand the definition of "homeless veterans." Our country's homeless problem is a national disgrace that refuses to fade. Homelessness has varied definitions and many contributing factors. Among these are PTSD, a lack of job skills and education, substance abuse, and mental-health problems. The homeless require far more than just a home. A comprehensive, individualized assessment and a rehabilitation/treatment program, utilizing the continuum of care concept, are necessary. Assistance in obtaining economic stability for a successful self-sufficient transition back into the community is vital. Although many need help with permanent housing, some require long-term residential care. VVA thanks the administration and the leadership on both sides of the aisle and in both the House and the Senate, for your continued support on ending homelessness among veterans.

VVA supports H.R. 627 as written.

H.R. 1369, the Veterans Access to Extended Care Act of 2015, introduced by Congresswoman Jackie Walorski, (IN-2), would modify the treatment of agreements entered into by the Secretary of Veterans Affairs to furnish nursing home care, adult day health care, or other extended care services.

VVA favors enactment of this bill.

H.R. 1575, introduced by Congresswoman Corrine Brown (FL-5), would amend title 38, United States Code, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

The nature of combat in Iraq and Afghanistan has put service members at an increased risk for PTSD compared to those of past wars. Many have served multiple tours of duty in a combat theater of operations, and the intensity of these conflicts is strong and constant. In these wars without fronts, combat support troops are just as likely to be affected by the same traumas as combat arms personnel.

This has particularly important implications for our female soldiers, who now constitute about 15 percent of our active duty fighting force. Studies on women serving in combat zones in prior conflicts have found that women who experience sexual trauma had significantly higher rates of PTSD than women who had not experienced MST. Therefore, many of the women who have served in Iraq and Afghanistan face dual causes of PTSD. Studies conducted at the Durham, North Carolina VAMC's Comprehensive

Women's Health Center have demonstrated higher rates of suicidal tendencies among women veterans suffering depression with co-morbid PTSD.

Because of the number of women veterans who are now *de facto* combat veterans and because of the nature of conflicts in Afghanistan and particularly Iraq, women veterans have entered a whole new world of need. The traumatic wounds of war often go unrecognized and undiagnosed for years. VVA believes that making this program permanent, and bringing it to scale system-wide, will help our women veterans to begin to heal. It bears repeating that women veterans, particularly those who have experienced sexual assault, often don't self-identify as needing treatment.

VVA fully supports this bill and would also suggest that the scope of the legislation be inclusive of all women who served in the Armed forces.

Mr. Chairman, Ranking Member Brownley, and distinguished Members of this Subcommittee, this concludes the testimony of Vietnam Veterans of America. I will be more than happy to answer any questions that the committee may have.

VIETNAM VETERANS OF AMERICA
Funding Statement
April 23, 2015

The national organization Vietnam Veterans of America (VVA) is a non-profit veteran's membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the Senate of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Executive Director for Policy and Government Affairs
Vietnam Veterans of America.
(301) 585-4000, extension 127

JOHN ROWAN

John Rowan was elected National President of Vietnam Veterans of America at VVA's Twelfth National Convention in Reno, Nevada, in August 2005.

John enlisted in the U.S. Air Force in 1965, two years after graduating from high school in Queens, New York. He went to language school, where he learned Indonesian and Vietnamese. He served with the Air Force's 6990th Security Squadron in Vietnam and at Kadena Air Base in Okinawa, helping to direct bombing missions.

After his honorable discharge, John began college in 1969. He received a BA in political science from Queens College and a Masters in urban affairs from Hunter College, also from the City University of New York. Following his graduation from Queens College, John worked in the district office of Rep. Ben Rosenthal for two years. He then worked as an investigator for the New York City Council and recently retired from his job as an investigator with the New York City Comptroller's office.

Prior to his election as VVA's National President, John served as a VVA veterans' service representative in New York City. John has been one of the most active and influential members of VVA since the organization was founded in 1978. He was a founding member and the first president of VVA Chapter 32 in Queens. He served as the chairman of VVA's Conference of State Council Presidents for three terms on the national Board of Directors, and as president of VVA's New York State Council.

He lives in Middle Village, New York, with his wife, Mariann.

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TO THE MEN AND WOMEN WHO SERVED

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STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 23, 2015

Mr. Chairman and Members of the Committee:

Thank you for inviting the DAV (Disabled American Veterans) to testify at this legislative hearing of the House Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of 1.2 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

DAV is pleased to be here today to present our views on the bills under consideration by the Subcommittee.

Draft – to improve the reproductive treatment provided to certain disabled veterans

This draft measure aims to improve the reproductive treatment provided to disabled veterans, regardless of their gender, if they are enrolled in the Department of Veterans Affairs (VA) health care system and have a service-connected disability related to injury of the reproductive organs or spinal cord which directly results in being unable to procreate without assisted reproductive technology, to include the spouse of a covered veteran.

This bill would add section 1720H under Chapter 17 of title 38, United States Code, titled, "Reproductive Treatment for Certain Disabled Veterans," that would enhance VA's current reproductive technology by stipulating that the Department shall furnish assisted reproductive technology to a covered individual consisting of a maximum of three cycles of in vitro fertilization and up to six implantation attempts.

This measure would also allow for the cryogenic storage of genetic material of a covered individual for up to three years, after which the covered individual would be financially responsible for maintaining storage. The Secretary may not possess, or make any determination regarding the disposition of, genetic material of a covered individual and would be bound by the State law where the genetic material is located. Further, the Secretary may not provide any benefits relating to surrogacy or third-party genetic material donation.

For the purpose of clarity, the term "assisted reproductive technology" includes in vitro fertilization or any other accepted medical technology used to assist reproduction VA determines appropriate for purposes of this section.

While DAV has no specific resolution from our membership related to reproductive and infertility treatment, this bill is focused on improving VA's authority to meet the long-term reproductive health care needs of veterans who have a service-connected condition that affects their ability to reproduce. For these reasons, DAV looks forward to the favorable consideration of this bill.

Draft bill – to direct the Secretary of Veterans Affairs to submit an annual report on the Veterans Health Administration and the furnishing of hospital care, medical services, and nursing home care by the Department of Veterans Affairs.

This bill, if enacted, requires VA submit an annual report to the House and Senate Committees on Veterans' Affairs, and would require analyses and detail of certain access, performance, quality, workload, human resources utilization, and other activities in and of VA health care, several of which would be comparisons to the prior year's activities.

We note the report required by this legislation focuses only on one of three pillars which enables the Veterans Health Administration (VHA) to furnish holistic health services to wounded, injured and ill veterans across all 50 states, the District of Columbia and U.S. territories. Specifically, the report would not provide an assessment or evaluation on VHA's management of veteran-centric research and management of possibly the largest medical education training program in the world.

As the Subcommittee is aware, VHA's research mission leads to advances in medical care on numerous topics, including post-traumatic stress disorder, traumatic brain injury, and prosthetics. Equally essential to building and maintaining proficiency of care is its training mission, where VHA annually trains, educates and provides practical experience for 62,000 medical students and residents, 23,000 nurses and 33,000 trainees in other health fields — people who go on to provide health care not just to veterans but to most Americans.

Pertaining to the language outlining the content of the report, the Subcommittee's professional staff may wish to consult with VA staff to ensure the bill produces meaningful reports that serve Congress' oversight responsibility. For example, adjustments may be needed to the amount of time necessary to produce an insightful evaluation of the effectiveness of a health care system to increase access to care and quality without increasing costs for more than 150 hospitals, 186 multispecialty outpatient clinics, 568 primary care outpatient clinics, 300 Vet Centers, and 135 Community Living Centers, mobile medical clinics, mobile Vet Centers and telehealth programs. The use of terms such as "the productivity of physicians and other employees," "pharmaceutical prices," and "the percentage of … care provided to such veterans in Department facilities and non-Department facilities" could be subject to variable interpretations and assessments depending on the standards chosen to compare or contrast.

We note also this bill is silent on whether the VA report would be made for the Department's health care system as a whole, by Veterans Integrated Service Network (VISN), or by VA facility. Because of VHA's decentralized status, we believe Congress, DAV, other veterans service organizations, and other VA stakeholders could benefit from learning about the variability of these patient care, workload, and human resources activities at the local and/or regional level, rather than as one nationwide review without granularity. We recommend the Subcommittee considers such a change in this legislation. Finally, we recommend these reports be reviewed and certified by the Office of Inspector General before they are released.

H.R. 271 – The Creating Options for Veterans Expedited Recovery Act/The COVER Act

This bill would establish a new commission, the "Veterans Expedited Recovery Commission." The commission would be established and would function along similar lines to that of the Commission on Care mandated in Public Law 113-146, the Veterans Access, Choice and Accountability Act of 2014. Members of the commission would be selected proportionately by the President and the House and the Senate leadership.

The commission would be established to review VA's efforts on advancing wellness in veterans challenged by mental illnesses. The commission's charge would be broad-based, to investigate directly and through surveys various aspects of the use of evidence-based therapies; the prescribing of psychopharmacological agents and practices in the treatment of mental illnesses in veterans; the experience of veterans in seeking mental health services both within VA and in non-VA facilities and providers; VA's outreach efforts, and; pertinent research and present use of complementary and alternative approaches in dealing with mental illnesses of veterans.

The commission would be required to provide its final report not more than 18 months after it first meets, and the Secretary would be required to provide Congress a report on the recommendations of the commission not more than 90 days afterward.

In accordance with DAV National Resolution No. 220, approved by our membership at our most recent National Convention, assembled in Las Vegas, Nevada, August 9-12, 2014, DAV supports the intent of this bill, and we thank the sponsor for introducing it. In addition to our resolution, as a partner organization of the *Independent Budget* DAV has long supported the advent of complementary and alternative therapies in VA health care for all generations of wounded, injured and ill veterans.

The most prevalent reported health consequence in veterans of combat deployments to Iraq and Afghanistan deals with musculoskeletal injury, followed closely by mental health and post-deployment readjustment challenges. In the view of DAV, VA's Vet Center program, which employs non-drug psychological counseling (including the use of peer counselors), could be considered a model of complementary and alternative treatment; this program has been universally praised by Iraq and Afghanistan veterans. We believe more such non-drug reliant approaches should be advanced.

We call the Subcommittee's attention to language on page 4, lines 11-18 of this bill that may need clarification as to intent. Unclear to us is whether the commission would be expected to study the Veterans Benefits Administration's management of mental health disability claims as a proxy for determining the resources needed in VHA to care for the veterans associated with these claims; or, whether the term "claims" should be replaced by a different expression.

H.R. 627 – to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs.

This measure would expand the definition of homeless veteran or veteran's family to include those fleeing domestic or dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions related to the individual's or family's current housing situation. The veteran or family must have no other residence, resources or support networks to obtain other permanent housing.

DAV Resolution No. 203 supports sufficient funding to improve services for homeless veterans in concert with VA's efforts to prevent and end homelessness among our nation's veterans. While our resolution does not include a specific provision on expanding the definition of homeless included in the bill, the provision is in line with supporting VA's efforts to assist veterans that find themselves without stable housing, resources or support networks to permanent housing despite the reason. For these reasons we have no objection to favorable consideration of this measure.

H.R. 1369 – the Veterans Access to Extended Care Act of 2015

Extended care services encompass the broad range of medical and personal care assistance veterans need when they have difficulty or inability with daily tasks (such as eating, bathing, getting dressed, preparing meals, and managing medication or money). Many severely wounded, injured and ill veterans receive extended care at VHA's expense through the use of provider agreements.

Congress passed the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (Public Law 108–170), giving VA the authority to use Medicare or state procedures to enter into agreements with providers to obtain extended care services for veterans. On February 13, 2013, VA issued a notice of proposed rulemaking to implement this new authority, which has been stalled with no clear sign if and when a final rule will be made. Because regulations have not been made final, no new provider agreements are being issued by VHA and existing provider agreements set to expire are not being renewed, effectively disrupting the continuity of extended care services for many service-connected disabled veterans.

DAV thanks the sponsors for introducing H.R. 1369, which would modify the treatment of VHA's authority to enable entering into provider agreements with selected extended care facilities. The intent of measure is consistent with DAV Resolution No. 209, which calls for legislation to enhance VA's extended care program for service-connected disabled veterans.

However, thousands of severely disabled veterans receive services in places other than extended care facilities, such as in their home and community or in an institutional setting at VA's expense through the use of provider agreements. For example, if the measure as currently written were enacted, it would not address concerns in VA's Veteran-Directed Home and Community Based Services (VD-HCBS) program, currently operating in 47 VA Medical Centers in 27 States and the District of Columbia. In fact, the VD-HCBS program in Arkansas serving over 30 veterans was recently terminated while the program in Hawaii remains on hold and unable to assist veterans.

We have shared legislative language with the Subcommittee pertaining to the concerns of VD-HCBS and look forward to its favorable consideration along with H.R. 1369. Without such language as part of the final legislation, this program may subsequently be terminated in other states, including Florida, Idaho, Illinois, Louisiana, Maine, Massachusetts, Michigan, Minnesota, New York, Oregon, South Carolina, Texas, and Wisconsin. Over 400 veterans would be forced out of this program and obtain less efficient types of care at greater cost to the taxpayer—none of which reflects their personal choices and preferences. Rest assured DAV will continue working the Subcommittee and VA to advance a bill ensuring the Department has the authority it needs to enable veterans to received extended care services.

On a broader level, this legislation and the legislative language DAV recommends is a piecemeal approach that may fall short of VA's long-term requirements to ensure a smooth delivery of services disabled veterans. In its most recent budget request, VA proposes updating its authorities, including its provider agreement authority, used for purchasing medical care. According to VA, its proposed language will streamline and speed the business process for purchasing care for an individual veteran when necessary care cannot be purchased through existing contracts or sharing agreements. We urge the Subcommittee and VA work on this proposed language to ensure veterans are not encumbered in receiving comprehensive and integrated care in their community.

H.R. 1575 – to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

This bill would make permanent, beginning January 1, 2016, VA's pilot program on counseling retreats for newly separated women veterans. Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, authorized VA to establish a pilot program designed to evaluate the feasibility of providing reintegration and readjustment services in group retreat settings to recently separated women veterans, after a prolonged deployment.

Participation is voluntary and services provided under the pilot program include information and assistance on reintegration into family, employment, and community; financial and occupational counseling; information and counseling on stress reduction and conflict resolution; and any other counseling VA considers appropriate to assist the participants in reintegrating into their families and communities.

Also required under Public Law 111-163 is VA's report to Congress assessing this pilot counseling program in retreat settings. The report describes the program as successful at improving the ability for women veterans to reintegrate and readjust to civilian life.

We thank the Committee for its continued efforts on improving VA's women veterans' health programs and services and are pleased to support this bill in keeping with DAV Resolution No. 040, which supports enhanced medical services and benefits for women veterans. The provisions of the measure are also consistent with DAV's Report, *Women Veterans: The Long Journey Home*.

H.R. 1769 – The Toxic Exposure Research Act of 2015

The 2008, 2010 and 2012 Institute of Medicine (IOM) Committees to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides concluded there is a plausible basis that male veterans exposed to the herbicides in Vietnam could result in adverse effects in are being manifested in the adult children and grandchildren as a result of epigenetic changes, and such potential would most likely be attributable to the TCDD contaminant, the most toxic form of dioxin in Agent Orange.

The 2012 Agent Orange study Committee reported it favors renewed efforts to conduct epidemiologic studies on all the developmental effects in offspring that may be associated with paternal exposure. In addition, new studies should evaluate offspring for defined clinical health conditions that develop later in life, focusing on organ systems that have shown the greatest effects after maternal exposure, including neurologic, immune, and endocrine effects. Finally, although the committee recognizes that there is evidence that environmental exposures can affect later generations, epidemiologic investigation designed to associate toxic exposures with health effects manifested in later generations will be even more challenging to conduct than research on adverse effects on the first generation.

While TCDD mostly associated with herbicide exposed Vietnam veterans, it is also one out of 56 pollutants, including several types of dioxins, of interest to the 2011 IOM Committee on the Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan.

This measure would establish in VA a national center to conduct research on the diagnosis and treatment health conditions of the descendants of veterans exposed to any toxic substances during service provided those health conditions are related to the veteran's exposure. The bill would also establish an advisory board.

Although DAV does not have a resolution from our membership to support this legislation, we encourage the Subcommittee and VA work together to ensure the legislation fulfills the IOM Committee recommendations.

This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Subcommittee Members concerning our views on these bills.

STATEMENT OF

RAJIV JAIN, MD

ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

April 23, 2015

Good Morning Mr. Chairman. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) benefits programs and services. Today we will be discussing legislation pertaining to Department of Veterans Affairs (VA) programs: H.R. 271, H.R. 627, H.R. 1369, H.R. 1575, H.R. 1769, draft bill to improve reproductive treatment provided to certain disabled Veterans, and a draft bill to direct VA to submit and annual report on the Veterans Health Administration (VHA). Joining me today is Janet Murphy, VHA's Acting Deputy Under Secretary for Health for Operations and Management, and Jennifer Gray, Attorney in the Office of General Counsel.

H.R. 271

H.R. 271 would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental health illnesses of Veterans and the potential benefits of incorporating complementary alternative treatments available in non-VA medical facilities within the community. More specifically, section 2 would establish a Veterans Expedited Recovery Commission (the "Commission") that would be charged with:

- Examining the efficacy of VA's evidence-based therapy model in the treatment of mental health illnesses and identifying areas to improve wellness-based outcomes;
- Conducting a patient-centered survey within each of the Veterans Integrated Service Networks (VISN) of Veterans seeking mental health services;
- Examining research on the benefits of complementary alternative treatment therapies for mental health issues, as specified by the bill; and
- Studying the potential increase of claims related to mental health issues submitted to VA by Veterans who served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

Section 3 would set forth the manner of appointing members. In general, it would require the Commission to be composed of 10 members, each of whom has recognized standing and distinction within the medical community, a background in treating mental health, experience working with the military and Veteran population, and no financial interest in any of the complementary alternative treatments reviewed by the

Commission. The President of the United States would be required to designate the chairman from among the members. Members would serve for the life of the Commission, and any vacancy would be required to be filled in the same manner as the original appointment. The measure would require these appointments to be made not later than 90 days after enactment.

Section 4 would require the Commission to hold its first meeting not later than 30 days after a majority of members are appointed and regular meetings thereafter. This measure would, among other things, authorize the Commission to take testimony and receive evidence; secure needed information directly from any Federal Department or Agency; and consult with private and public sector entities. It would also authorize a Federal department or agency, upon request, to detail personnel (on a reimbursable basis) to assist the Commission, but require the Administrator of General Services to provide (on a reimbursable basis) administrative support services requested and required by the Commission.

Section 5 would require submission of interim, periodic, and final reports to Congress, the President, and the Secretary of Veterans Affairs.

Section 6 would provide for the Commission's termination 30 days after the submission of its final report.

While VA supports the intent of H.R. 271 to examine the efficacy of VA treatment of mental disorders, we do not support the manner in which this bill would carry out that goal for the reasons discussed below. In addition, VA's current programs and reviews, as explained below, have substantial overlap with many elements of the work the Commission would do. Finally, the charge of the Commission to examine the efficacy of

VA's "evidence-based therapy model" in the treatment of mental health illnesses may be based on a flawed premise, as no single evidence-based therapy model exists by which to treat all mental health issues in Veterans who use VA health care.

Treatment is guided, in part, by the Post-traumatic Stress Disorder (PTSD) Practice Guideline (Guideline) that was jointly developed by VA and the Department of Defense (DoD) in 2010. The bill's charge to examine the efficacy of VA treatments would partially duplicate the Guideline as well as a report issued by the Institute of Medicine, entitled "Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment," in June of 2014. Creating such a Commission would also duplicate the efforts of the Institute of Medicine committee that is currently evaluating VA's mental health services. See "Evaluation of the Department of Veterans Affairs Mental Health Services."
http://www.iom.edu/activities/Veterans/vamentalhealthservices.aspx

As to the mandated patient-centered survey to be conducted by the Commission, such a charge would be unnecessarily burdensome to Veterans because some of the required information is already available in research programs and program evaluation studies. Other mandated information will be collected as part of VA data collection initiatives currently in development. Veterans should not be burdened by collection of information that is already available within VA or soon will be.

VA research into the benefits of complementary and alternative medicine (CAM) is also already underway. VHA is also establishing the Integrative Health Coordinating Center (IHCC) within the Office of Patient-Centered Care and Cultural Transformation. Integrative Health reflects the practice of medicine that reaffirms the importance of the

relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, health care professionals, and disciplines to achieve optimal health and healing. Integrative Health is inclusive of CAM. The IHCC is charged to work with VHA Mental Health Services, Patient Care Services, the Office of Research and Development, and other VHA program offices to examine the evidence and potential benefits of incorporating complementary and alternative treatments. VHA is actively partnering with the National Institutes of Health, National Center for Complementary and Integrative Health to evaluate the evidence. Thus, VA is already engaged in robust CAM efforts.

The bill's requirement that the Committee conduct research on the benefits of CAM techniques is partially duplicative of the activity of the PTSD Practice Guideline Committee, which is currently preparing to update the Guideline. VHA continues to review the emerging literature in other ways too. For example, through its Evidence Synthesis Program, VHA issued a review of the evidence on CAM for PTSD. (See Efficacy of Complementary and Alternative Medicine Therapies for Posttraumatic Stress Disorder: Evidence-based Synthesis Program. Investigators: Jennifer L Strauss, PhD, Remy Coeytaux, MD, PhD, Jennifer McDuffie, PhD, Avishek Nagi, MS, and John W Williams, Jr., MD, MHSc. Evidence-based Synthesis Program (ESP) Center, Durham Veterans Affairs Healthcare System. Washington (DC): Department of Veterans Affairs; 2011 Aug.)

With respect to the requirement that the Secretary submit a plan to Congress in response to the Commission's final report, we believe the suggested timeframe

(90 days after the date the Commission submits it report) is not reasonable given the requirements of the legislation.

VA estimates the costs associated with enactment of H.R. 271 to be $770,512 over Fiscal Years (FYs) 2015 through 2017, the period covered by the legislation. This estimate does not include, however, contract-related costs required for the Commission to discharge its duties. Clarification of certain terms in the legislation and development of a scope of work are needed before contract-related costs and other costs associated with the legislation could be estimated and included in our cost projections.

In addition to these views, the Department of Justice advises us that it would treat section 4(c) of H.R. 271, authorizing the Veterans Expedited Recovery Commission to "secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out the duties of the Commission," consistently with executive privilege and the President's authority to control the dissemination of privileged information within the Executive Branch.

H.R. 627

H.R. 627 would expand the definition of "homeless veteran" found in 38 United States Code (U.S.C.) § 2002(1) to include "any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing." H.R. 627 would expand the definition by inserting "or (b)" to the

current title 38 definition, which would incorporate an additional subsection of the general definition of "homeless individual" found in the McKinney-Vento Homeless Assistance Act, 42 U.S.C. § 11302.

VA supports H.R. 627; however, a technical correction is needed to the bill language. Specifically, "or (b)" also needs to be added after "42 U.S.C. 11302(a)" in 38 U.S.C. 2002(1).

Since Veterans fleeing from domestic violence and interpersonal violence (DV/IPV) are considered at high risk for homelessness, they are already served in VA's homeless programs when it is clinically appropriate. Even when a VA homeless program is not a clinically appropriate placement for a Veteran affected by DV/IPV, VA works closely within the local community to identify resources best suited to the clinical needs of the Veteran.

VA's homeless programs may help prevent future DV/IPV by providing Veterans with alternative housing options so they can safely exit abusive relationships. VA remains committed to serving these Veterans, and VA homeless programs will continue to ensure those fleeing DV/IPV get the care and support they need.

VA is not able to provide an accurate cost estimate for H.R. 627 since we currently lack detailed data regarding the size and characteristics of this population; however, we anticipate H.R. 627 will be cost neutral since VA Homeless Programs already serve Veterans fleeing domestic violence, due to their high risk for becoming homeless.

H.R. 1369

Section 2 of HR 1369 would amend 38 U.S.C. § 1720(c)(1), to clarify that agreements for extended care services under that section shall not be treated as contracts for the acquisition of goods and services and are not subject to any provision of law governing federal contracts for the acquisition of goods or services. It would also require that any agreement with a provider specified in the section 1720 include provisions to ensure the safety and quality of care furnished to Veterans under those agreements. Specifically, agreements would have to include requirements as to the licensing and credentialing of the provider's medical professionals, site visits by VA, and review by VA of the medical records maintained by the provider as well as staffing levels for the provider's medical professionals and support personnel.

Section 3 of the bill would amend 41 U.S.C. § 6702(b) to exempt agreements under 38 U.S.C. § 1720 from certain labor laws.

VA appreciates the Committee's interest in updating our authority to purchase extended care services from community providers. As noted in VA's budget request, we are currently developing a legislative proposal to address our authority to purchase hospital care, medical services, and extended care services. We look forward to working with the Committee on this vital legislation.

H.R. 1575

HR 1575 would direct VA to provide reintegration and readjustment counseling services, in a retreat setting, to women Veterans who are recently separated from service in the Armed Forces after prolonged deployments.

VA is currently in the final year of a pilot program, authorized by Public Law 111-163 and subsequent laws (extensions), to determine the feasibility and advisability of such retreats. Under this program, six retreats were provided to women Veterans from 2011-2012, and three more are planned for calendar year 2015. These retreats focus on building trust and developing peer support for the participants in a therapeutic environment. Data has shown that those who participated in these retreats were able to increase their coping abilities and decrease their symptoms associated with PTSD. VA is expecting similar results for those who participate in the retreats in 2015. We will be happy to provide the Committee with a copy of the final report.

While VA agrees that providing these retreats is beneficial to women Veterans and authorization to provide them should be made permanent, other Veteran and Servicemember cohorts could also benefit from this treatment modality, conditioned on the availability of the additional resources needed to implement these provisions. VA recommends legislation to allow VA to provide these retreats to all Veteran or Servicemember cohorts eligible for Vet Center services. Examples could include those who have experienced a military sexual trauma, Veterans and their families, and families that experience a death of a loved one while on active duty.

VA estimates that this legislation would cost $456,000 to conduct six retreats in FY 2016, $2.5 million over five years, and $5.5 million over 10 years.

HR 1769

In general, this draft bill would require the Secretary to establish a National Center ("Center") charged with researching the diagnosis and treatment of health

conditions of descendants of individuals who were exposed to toxic substances while serving in the Armed Forces. It would also establish an Advisory Board (the "Board") to oversee and assess the Center and advise the Secretary as to the Center's work. The term "toxic substance" would be defined as any substance determined by the Environmental Protection Agency to be harmful to the environment or hazardous to the health of an individual if inhaled or ingested by or absorbed through the skin of the individual.

VA is committed to working with other Federal departments and agencies to ensure that Veterans exposed to toxic substances receive the best possible care we can provide and the benefits for which they are eligible. With respect to military exposures, VA is working closely with DoD to ensure that those who have transitioned to Veteran status are identified and provided information about their exposures. VA will also ensure their records document their exposures and they are provided access to the health care and benefits for which they are eligible.

Section 3 would require VA, in consultation with the Board, to select, not later than one year after the date of enactment, a VA medical center to serve as the Center for research on the diagnosis and treatment of health conditions of descendants of individuals exposed to toxic substances while serving in the Armed Forces that are related to such exposure. It would also establish selection criteria for the site and authorize the Center to conduct research on the diagnosis and treatment of health conditions of such descendants. In conducting such research, the Center would be required, at the election of the individual, to study individuals for whom the Secretary has made one of the following determinations:

- The individual is a descendant of an individual who served as a member of the Armed Forces; such member was exposed to a toxic substance while serving as a member of the Armed Forces; and such descendant is afflicted with a health condition that is related to the exposure of such member to such toxic substance.
- The individual was exposed to a toxic substance while serving as a member of the Armed Forces, and such individual is afflicted with a health condition that is related to the exposure of such individual to such toxic substance.

Section 3 would further require the Secretary of Defense or the head of a Federal agency to make available for review records held by DoD, an Armed Force, or the Federal agency, as appropriate, that might assist the Secretary in making the determinations described above. Moreover, the Center would need to employ not less than one licensed clinical social worker to coordinate access of individuals to appropriate Federal, State, and local social and healthcare programs and to handle case management; plus it would need to reimburse the reasonable costs of travel and lodging of any individual participating in a study at the Center (and those of any parent, guardian, spouse, or sibling who accompanies the individual). This section would also require the Center to submit an annual report to Congress and to the Board that summarizes, for the preceding year, all completed research efforts and identifies on-going research efforts. A copy of such report would also have to be released to an organization that requests it, if the organization has tax exempt status as an organization of past or present members of the Armed Forces or an auxiliary unit under

section 501(c)(19) of the Internal Revenue Service Code of 1986. The Center would also be required to submit quarterly reports to the Board.

Section 4 would require the Secretary to establish, not later than 180 days after the date of enactment of this legislation, a Board that would be tasked with overseeing and assessing the Center and also advising the Secretary with respect to the Center's work. Among its duties, the Board would advise the Secretary on issues related to the research conducted at the Center; health conditions of descendants of individuals exposed to toxic substances while serving as members of the Armed Forces that are related to the exposure of such individual to such toxic substance; health care services that are needed by the descendants of individuals exposed to toxic substances while serving as members of the Armed Forces for health conditions that are related to the exposure of such individual to such toxic substance; and, any determinations or recommendations that the Board may have with respect to the feasibility and advisability of VA providing such health care services to those descendants, including a description of changes to existing policy.

Section 5 would require the Secretary of Defense, unless excepted for reasons of national security, to declassify documents related to any known incident in which not fewer than 100 members of the Armed Forces were exposed to a toxic substance that resulted in a least one case of a disability that a member of the medical profession has determined to be associated with that toxic substance. It would limit such declassification to information needed to determine whether an individual was exposed to the toxic substance, the potential severity of the exposure, and any potential health conditions that may have resulted from the exposure.

Section 6 would require the Secretary, in consultation with the Secretaries of Health and Human Services and Defense, to conduct a national outreach and education campaign directed toward members of the Armed Forces, Veterans, and their family members.

Section 7 of the bill would provide that no additional funds are authorized to be appropriated for the conduct of this program.

However, VA does not support the draft bill. Other Federal departments and agencies are better poised to support research on multi-generational health effects of toxic exposures. Large populations are needed to study rare multi-generational effects appropriately. Focusing solely on military exposures – which can often be similar to many civilian exposures – will likely result in inconclusive research. VA's approach is to monitor Veterans' health, conduct surveillance studies, and remain abreast of findings from well-conducted studies in other populations. New Veteran-centric studies are conducted when indicated by clinical care findings or surveillance, or when the clinical or scientific community indicates a need exists for the conduct of such studies, or when such research is likely to yield new insights. None of those reasons applies here.

Moreover, the proposed Center would duplicate work done by the National Institute of Environmental Health Sciences, the Centers for Disease Control and Prevention, the Agency for Toxic Substances and Disease Registry, VHA (the War Related Illness and Injury Study Center, the Office of Research and Development, and the Office of Public Health), as well as other governmental and non-governmental scientific organizations. For many years, these existing organizations have conducted research on the health effects of a myriad of environmental exposures. Despite these

efforts, few diseases have been shown to be caused solely by exposure to environmental toxicants, and far fewer studies have demonstrated adverse health effects among the descendants of the exposed populations or adverse health effects specific to military service. Establishing a Center dedicated primarily to the study of adverse health effects on descendants, as proposed, would have little scientific-knowledge base and so would be premature. Existing agencies and research organizations should undertake preliminary research, as indicated by clinical findings, before a new Center for multigenerational research is created. We are also concerned that the draft bill's provisions related to the Board are impracticable, as the amount of work expected of the Board would be excessive for what is essentially a volunteer group of (at least) 13 members. We also note it is unclear what is contemplated by the provision in the draft bill that would require the licensed clinical social worker(s) at the Center to "coordinate access of individuals to appropriate Federal, State, and local social and healthcare programs and to handle case management."

With respect to researching the diagnosis and treatment of adverse health effects related to exposure from toxic agents, we underscore that the scientific approach generally does not differ whether the exposure occurred while performing in a military occupation or in a civilian occupation. It is also unclear whether the focus of such a Center would be to determine additional unknown health outcomes from exposure or translate known health outcomes of exposure – typically best determined by research in non-military populations – to the Veteran population. As to the field of research, the draft bill would require VA to determine whether an eligible descendant of an individual who served in the Armed Forces has a health condition that is related to the individual's

exposure to a toxic substance while serving in the Armed Forces. It is unclear what role the Center would have in researching potential exposures that have not been determined to be related to military service. However, a more fundamental problem is that exposure research typically looks at populations and does not provide the level of information necessary to determine causation at the individual level. As a result, many of the apparent goals of the draft bill could not be achieved.

In addition, the Department of Justice advises us that it opposes the inclusion of section 5 in the HR 1769 on the ground that it interferes with the President's exclusive authority to "classify and control access to information bearing on national security." Dep't of Navy v. Egan, 484 U.S. 518, 527 (1988).

Without authorization for additional appropriations to carry out the program established by the draft bill, resources would have to be taken from existing programs for Veterans should the draft legislation be enacted. VA estimates the costs associated with enactment of the draft bill to be $7.2 million for FY 2015; $96 million over a 5-year period; and $222 million over a 10-year period.

Draft Bill on Annual Report Requirement

This draft bill would require VA to submit an annual report to the Senate and House Committees on Veterans' Affairs on the furnishing of hospital care, medical services, and nursing home care that VHA provides. The report would contain an evaluation of the effectiveness of VHA's program to increase access of eligible Veterans, an evaluation of effectiveness of VHA in improving the quality of health care services to Veterans, and information about VHA employee workload, patient

demographics and utilization rates, physician compensation, VHA employee productivity, the percentage of care provided in VA facilities compared to non-VA facilities, and pharmaceutical prices.

The Department appreciates the intent of this bill but notes that the bill may be unnecessary, as the data and related measures contemplated by the bill are already compiled as part of an ongoing and automated process for data that are available publicly and also in response to the requirements of the Veterans Choice Act. Additionally, VA currently provides reports and data on an annual, bi-annual or quarterly basis on programs and subjects such as homelessness, mental health, nursing education, and contracted care to name a few. Furthermore, pharmaceutical pricing information is already compiled and available on VA's Internet site. VA would be happy to brief the Committee on the various types of information currently compiled and disseminated on VHA programs and organization structure including the 32 Congressionally Mandated Reports and the 62 Congressional Tracking Reports that are required under law.

VA estimates that there would be negligible costs associated with this bill.

Draft Bill to Improve the Reproductive Treatment Provided to Certain Disabled Veterans

The draft bill would add a new section 1720H to title 38 of the U.S.C., to require the Secretary to furnish assisted reproduction technology to covered individuals. "covered individuals" would mean: 1) a Veteran, regardless of sex, who is enrolled in VA's health care system and who has a service-connected disability that includes an

injury to the reproductive organs, or to the Veteran's spinal cord, and such injury directly results in the Veteran being unable to procreate without assisted reproductive technology; and 2) the spouse of such a Veteran. Notably, such medical services would be in addition to any other fertility treatment otherwise furnished by VA.

The draft legislation would further define assisted reproductive technology to include in vitro fertilization or any other specific technology used to assist reproduction that the Secretary determines is appropriate. It would also provide that when the type of assisted reproductive technology provided under this new section consists of in vitro fertilization, the Secretary would be limited to providing no more than three in vitro fertilization cycles that result in a total of not more than six implantation attempts. The draft bill would also authorize the Secretary to provide for cryogenic storage of genetic material for individuals receiving services under this section for a period not exceeding three years, after which time the individual would be required to pay for any costs relating to such storage. The Secretary would be prohibited from possessing or making any determination regarding the disposition of a covered individual's genetic material and would be required to carry out any activities relating to the custody or disposition of genetic material of a covered individual in accordance with the laws of the State in which the genetic material is located. Finally, the draft bill would further prohibit the Secretary, when providing services under this section, to provide any benefits relating to surrogacy or third-party genetic material donation.

VA supports this draft legislation, conditioned on the availability of the additional resources needed to implement this provision. The provision of assisted reproductive technologies (including any existing or future reproductive technology that involves the

handling of eggs or sperm) is consistent with VA's goal to restore, to the greatest extent possible, the physical and mental capabilities of our enrolled Veterans. From a clinical perspective, this is particularly important given that the inability to be a biological parent can lead some to develop depression or other mental health conditions.[1] We note, however, that enrolled Veterans who have lost reproductive function for clinical reasons not covered by the draft legislation, for example, Veterans who have lost reproductive function due to some disease process or as a result of treatment for some other service-connected disability, could feel they were being treated inequitably by the Department based on their exclusion under this bill.

VA estimates costs associated with enactment of the draft bill to be as follows: $177 million (consisting of approximately $64 million for Veterans and $113 million for eligible spouses). Expenditures are expected to decline to approximately $80 million in FY 2017, gradually increasing to $154 million by FY 2025. Total expenditures from FY 2016 to FY 2025 are expected to be approximately $1,207 million (approximately $437 million for disabled Veterans and $769 million for eligible spouses). Expenditures for pregnancies resulting from fertility services are estimated to be $28.9 million from FY 2016 through FY 2025.

Please note that the chart below summarizes what is currently available through VA in the field of reproductive care.

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[1] 1. Chachamovich JR, Chachamovich E, Ezer H, Fleck MP, Knauth D, Passos EP. Investigating quality of life and health-related quality of life in infertility: A systematic review. J Psychosom Obstet Gynaecol 2010;31:101–110.
2. Fisher JR, Hammarberg K. Psychological and social aspects of infertility in men: An overview of the evidence and implications for psychologically informed clinical care and future research. Asian J Androl 2012;14:121–129.
3. Klemetti R, Raitanen J, Sihvo S, Saarni S, Koponen P. Infertility, mental disorders and well-being–a nationwide survey. Acta Obstet Gynecol Scand 2010;89:677–682.
4. Smith JF, Walsh TJ, Shindel AW, et al. Sexual, marital, and social impact of a man's perceived infertility diagnosis. J Sex Med 2009;6:2505–2515.

Current Infertility Services offered through VA

Female Veterans	Male Veterans
•Laboratory blood testing •Genetic counseling and testing •Pelvic and/or transvaginal ultrasound •Hysterosalpingogram (HSG) •Saline infused Sonohysterogram •Surgical correction of structural pathology including operative laparoscopy, operative hysteroscopy and reversal of tubal ligation •Intrauterine Insemination (IUI) and Hormonal Therapies •Hormonal therapies for ovulation induction for IUI	•Laboratory blood testing •Genetic counseling and testing •Semen analysis •Evaluation and treatment of erectile dysfunction (e.g., in spinal cord injury) •Surgical correction of structural pathology •Vasectomy reversal •Hormonal therapies •Sperm retrieval techniques •Post-Ejaculatory urinalysis •Transrectal and/or scrotal ultrasonography •Sperm cryopreservation

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I would be pleased to respond to questions you or the other Members of the Subcommittee may have regarding our views as presented.

STATEMENT FOR THE RECORD

STATEMENT OF HON. CORRINE BROWN, FULL COMMITTEE, RANKING MEMBER

Women Veterans Readjustment and Reintegration

Mr. Chairman and Members of the Committee, I would like to offer this testimony on behalf of H.R. 1575, legislation to honor the service and sacrifice of our heroic women veterans recently separated from military service after prolonged deployments. This bill extends and makes permanent a very successful pilot program at the Department of Veterans Affairs which provides psychiatric and psychological counseling and support in retreat settings for newly returned women veterans.

This legislation follows the release of a report by the Veterans Health Administration showing that this limited, 2-year pilot program, run by the Readjustment Counseling Service, has shown positive, measurable results helping returning women veterans experiencing post-traumatic stress, depression, sleep disturbances and isolation. Many of these servicewomen have been evaluated as service connected for severe PTSD.

In surveys, participants have consistently reported experiencing a marked decrease in stress symptoms and an increase in coping skills, including understanding better how to develop support systems and to access available resources at VA and in their communities following the program and as they reenter civilian life.

The Veterans Health Administration has completed six retreats in the two year pilot period. Post 9/11 women veterans, often combat veterans, are brought together in groups of about 20, in outdoor settings. Transportation is paid for. These one-week sessions were held in California, Colorado, New Mexico and Connecticut. The veterans, most of whom are coping with the effects of severe PTS, some as a result of sexual trauma while in the military, participated in trust building exercises and worked with counselors and psychological educators to build peer support. Other services offered on an as-needed basis are financial and occupational counseling and conflict resolution training.

H.R. 1575 provides VA with permanent authority to extend the program using the same measurements and eligibility requirements in the original law, P.L. 111–163. This expansion will mean an increase in the number of sessions and locations for the program. VA must submit a report to Congress every two years on the program.

This program is limited, well run and highly successful thereby providing us with a bit of good news and, more importantly, a chance to ensure a healthier, more successful transition back to civilian life for a specific group of heroic women warriors.

I appreciate the opportunity to provide this testimony on behalf of H.R. 1575, invite my colleagues' support, and look forward to its enactment as soon as possible.

AMERICAN HEALTH CARE ASSOCIATION

Dear Chairman Dan Benishek:

I serve as the president and chief executive officer of the American Health Care Association (AHCA), the nation's largest association of long term and post-acute care providers. The association advocates for quality care and services for the frail, elderly, and individuals with disabilities. Our members provide essential care to millions of individuals in more than 12,000 not for profit and for profit member facilities.

AHCA, its affiliates, and member providers advocate for the continuing vitality of the long term care provider community. We are committed to developing and advocating for public policies which balance economic and regulatory principles to support quality of care and quality of life. Therefore, I appreciate the opportunity today to submit a statement on behalf of AHCA for the hearing record in strong support of the Veterans Access to Extended Care Act (H.R. 1369/S. 739), which would grant the U.S. Department of Veterans Affairs (VA) the legislative authority to enter into Provider Agreements for extended care services.

The VA released a proposed rule, RIN 2900–A015, on Provider Agreements in February of 2013. This important rule, among other things, increases the opportunity for veterans to obtain non-VA extended care services from local providers that furnish vital and often life-sustaining medical services. This rule is an example of how government and the private sector can effectively work together for the benefit of veterans who depend on long term and post-acute care. Last Congress, close to half of the U.S. Senate chamber and 109 U.S. House members signed onto a letter to the VA encouraging the release of the final VA provider agreement rule. It was determined that the VA needs the legislative authority to enter into these agreements, which the Veterans Access to Extended Care Act provides.

It is long-standing policy that Medicare (Parts A and B) or Medicaid providers are not considered to be federal contractors. However, if a provider currently has VA patients, they are considered to be a federal contractor and under the Service Contract Act (SCA). The Veterans Access to Extended Care Act would ensure that providers could enter into VA Provider Agreements, and would therefore not have to follow complex federal contracting and reporting rules that come with being deemed a federal contractor or under the SCA.

Federal contracts come with extensive reporting requirements to the Department of Labor on the demographics of contractor employees and applicants, which have deterred providers, particularly smaller ones, from VA participation. The use of Provider Agreements for extended care services would facilitate services from providers who are closer to veterans' homes and community support structures. Once providers can enter into Provider Agreements, the number of providers serving veterans will increase in most markets, expanding the options among veterans for nursing center care and home and community-based services. Services covered as extended care under the proposed rule include: nursing center care,

geriatric evaluation, domiciliary services, adult day healthcare, respite care, and palliative care, hospice care, and home healthcare.

AHCA endorses H.R. 1369/S. 739, and applauds Congresswomen Jackie Walorski (R–IN–2nd) and Tulsi Gabbard (D–HI–2nd) and Senators John Hoeven (R–ND) and Joe Manchin (D–WV) for introducing this important legislation that will ensure that those veterans who have served our nation so bravely have access to quality healthcare. Thank you again for the opportunity to comment on this important matter.

Sincerely,

Mark Parkinson, AHCA/NCAL President & CEO

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

Dear Chairman Dan Benishek:

Thank you for the opportunity to offer comments regarding draft legislation to allow the Department of Veterans Affairs to provide reproductive treatment to disabled veterans that includes in vitro fertilization. The American Society for Reproductive Medicine is pleased that you have considered this bill for a public hearing. It is nothing but unjust to send our military personnel into harm's way and to not provide health care services to address health care needs that arise due to their service and dedication to our country. ASRM solidly supports the provision of fertility services to severely wounded veterans, particularly given that similarly situated individuals with coverage under TRICARE are allowed this covered benefit.

ASRM is a multidisciplinary organization of nearly 8,000 medical professionals dedicated to the advancement of the science and practice of reproductive medicine. ASRM members include obstetrician/gynecologists, urologists, reproductive endocrinologists, nurses, embryologists, mental health professionals and others. As the medical specialists who present treatment options for patients and perform procedures during what is often an emotional time for them, we recognize how important a means to addressing their medical condition can be for those hoping to build their families.

The draft legislation would direct the Secretary of Veterans Affairs to provide fertility treatment, including in vitro fertilization, to a disabled veteran who has an injury to his/her reproductive organs or spinal cord and such injury directly results in the veteran being unable to procreate without assisted reproductive technology. Importantly, the draft bill provides the same treatment for the veterans' spouse. We find that the coverage regarding number of in vitro fertilization attempts and number of years of storage of genetic material is reasonable. In providing for the coverage of cryopreservation of genetic material, we would recommend the bill specifically include gametes (sperm and egg) and also embryos that may be created as part of the assisted reproduction procedure. It is important that the cryopreservation of genetic material include gametes because the disabled veteran may not be in a position to begin the part of fertility treatment that includes in vitro fertilization until he/she is better able to emotionally and physically pre-

pare for that treatment. The cryopreservation of gametes allows for the processes of fertilization and transfer of any resulting embryos to occur when the patient is ready for that process.

The bill could go further to specifically include coverage of services to those affected by infertility caused by exposure to toxins during their deployment as these exposures can also compromise one's ability to reproduce. So too, fertility preservation is a common concern for military personnel with orders to deploy. While this is not currently a covered benefit under TRICARE and it is not within this panel's jurisdiction to make requirements of the TRICARE program, fertility preservation is an important topic to raise. The technology exists to provide these services. The nature of the promises we make to those individuals who risk everything for our country warrants a thoughtful examination of whether this benefit should also be part of the covered services for military personnel.

ASRM would further recommend that the bill allow for the use of donor gametes as part of the covered treatment options. For some severely injured veterans, sperm or egg retrieval may be impossible. The desire to have a family is no less important to those individuals and third party collaboration as a family building option is an appropriate medical option for some infertile patients.

The bill limits required treatments to disabled veterans or their spouse. Until such time that every state legally recognizes the marriage of same sex partners, the effect of this bill will be that only those veterans whose marriage is deemed legal will be furnished those services outlined in the bill. This effectively denies coverage to injured veterans who are single or who are in same sex partnerships. It is no longer a stigma to reproduce outside of the context of marriage, or a male/female marriage, and ASRM would recommend that holding veterans to a standard that is not the norm any longer in today's society is discriminatory just as denying to these individuals the ability to serve in the military.

Thank you for the opportunity to comment on this bill and for your attention to this important public health issue. Our nation's military personnel and veterans deserve to have access to the full complement of infertility treatments that are available and we are pleased that this committee has recognized the need to correct the inequities that exist between the health plans available under the DoD and the Veterans' Health plans.

Sincerely,

Rebecca Z. Sokol, MD, MPH, President,

American Society for Reproductive Medicine

CONCERNED VETERANS FOR AMERICA

Draft Legislation on Reproductive Treatment for Disabled Veterans

To amend title 38, United States Code, to improve the reproductive treatment provided to certain disabled veterans.

CVA has no position on this legislation.

Draft Legislation Requiring an Annual VHA Report

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to submit an annual report on the Veterans Health Administration and the furnishing of hospital care, medical services, and nursing home care by the Department of Veterans Affairs.

CVA supports the principles of the legislation, which requires more detailed reporting from VHA in important areas where data have been lacking. In order to ensure accountability, it is important that VHA report its performance numbers in a way that enables decision-makers and veterans to assess their efficiency and efficacy.

A CBO report released last December which examined the comparative cost of VA-provided healthcare versus and private-sector healthcare notes that "Comparing health care costs in the VHA system and the private sector is difficult partly because the Department of Veterans Affairs (VA), which runs VHA, has provided limited data to the Congress and the public about its costs and operational performance". [1]

This legislation would be an important step towards making sure that the VHA and the VA become more transparent institutions, which would benefit both the taxpayers and the veterans. While CVA remains committed to comprehensive reform of VHA and the Department of Veterans Affairs, these reporting requirements are an important step toward more accountability and better care for our veterans.

CVA supports this legislation.

Draft Legislation: The Toxic Exposure Research Act of 2015

To establish in the Department of Veterans Affairs a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces that are related to that exposure, to establish an advisory board on such health conditions, and for other purposes.

CVA has no position on this legislation.

HR 271: The Cover Act

To establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

CVA has no position on this legislation.

HR 627: To Expand of Definition of Homelessness

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[1] Congressional Budget Office. (2014). Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs (CBO Publication No. 49763). Washington, DC: U.S. Government Printing Office. Retrieved from *https://www.cbo.gov/sites/default/files/cbofiles/attachments/49763–VA—Healthcare—Costs.pdf.*

To amend title 38, United States Code, to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs.

CVA has no position on this legislation.

HR 1369: Veterans Access to Extended Care Act of 2015

To modify the treatment of agreements entered into by the Secretary of Veterans Affairs to furnish nursing home care, adult day health care, or other extended care services, and for other purposes.

CVA believes that this legislation represents a good step forward in alleviating the problems that the Department of VA has in providing veterans access to the care that they need and increasing the partnership between VA and private sector care, by simplifying the process that non-VA providers must go through to enable them to provide extended care to veterans. CVA strongly believes that it is important to ensure that there are more choices for veterans regarding the services that are available to them within the current overall institutional arrangement, and that VA should work with private-sector healthcare providers in effective ways to ensure that veterans receive the quality of care they deserve. This legislation is in keeping with that goal.

CVA supports this legislation.

HR 1575: Retreat Counseling for Women Veterans

To amend title 38, United States Code, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

CVA has no position on this legislation.

RESOLVE:

THE NATIONAL INFERTILITY ASSOCIATION

Dear Chairman Dan Benishek:

Thank you for the opportunity to provide this statement regarding draft legislation to improve reproductive treatment provided to certain disabled veterans. This is incredibly important legislation for our wounded warriors who expect our government to care for them if they are injured in their service to our country. The ability to procreate is the most basic and fundamental desire of human beings. If that ability is damaged as a result of their service, then we owe it to them to provide access to medical treatments that will allow them to become a parent.

RESOLVE: The National Infertility Association was founded in 1974 to provide information, support, awareness and advocacy for women and men living with infertility. RESOLVE is the oldest and largest patient advocacy organization in the U.S. and the only patient organization advocating for access to infertility services for our active duty military and veterans. We applaud the committee for discussing this important topic.

The draft legislation provides for certain disabled veterans to access in vitro fertilization (IVF). Right now the Veterans Administration is prohibited from providing access to IVF, which causes a

critical gap in coverage since that same benefit is offered to wounded service-members still covered under TRICARE. While the TRICARE supplemental benefit for certain wounded service-members is needed, most of those who could benefit from IVF transition to the Veteran's health system and by the time they are ready to become a parent, they discover that the VA does not provide access to IVF. This draft legislation will fix this gap in service and solve a major problem facing our disabled veterans.

This bill also provides for access to reproductive care for the spouse of a veteran. While the VA is not responsible for the healthcare of spouses and dependents, reproduction is unique in that male and female gametes (sperm and egg) are needed as well as a female to carry the pregnancy. Only providing care to the male or female does not work—both must be treated.

We do ask that the committee consider all of the injuries that may result in infertility, as the bill only covers injury to the reproductive organs or spinal cord. Amputations, Traumatic Brain Injuries and exposure to toxins and chemicals can also impact the ability to procreate without assisted reproductive technologies. All of our wounded veterans with infertility should have access to this coverage.

We applaud the committee for this important first step in opening up advanced reproductive care to veterans. We are hopeful that this first step will lead to further coverage in the future for all veterans, not just those with a service related injury; access to IVF for service-members covered under TRICARE; coverage for fertility preservation before deployment (the freezing of sperm, eggs and/or embryos); access to care for those who are single or not married with infertility; and coverage for the use of donor gametes (donated sperm, egg or embryos) for those who can no longer produce viable gametes to have a child.

We stand ready to work with Congress to get this important legislation passed as quickly as possible. Our Veterans are waiting—we owe it to them to fix this coverage gap with the VA and let them access the advanced medical care that they need and so deserve.

Sincerely,

Barbara L. Collura, President & CEO

RESOLVE: The National Infertility Association, 7918 Jones Branch Drive, Suite 300, McLean, VA 22102, *www.resolve.org bcollura@resolve.org*, 1–703–556–7172

VETERANS OF FOREIGN WARS OF THE UNITED STATES

Statement of Carlos Fuentes, Senior Legislative Associate National Legislative Service, Veterans of Foreign Wars of the United States APRIL 23, 2015

Mr. Chairman and Members of the Subcommittee:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, thank you for the opportunity to offer our thoughts on today's pending legislation.

H.R. 271, Creating Options for Veterans Expedited Recovery (COVER) Act:

The VFW supports this legislation, which would establish a commission to examine the efficacy of the Department of Veterans Affairs' (VA) mental healthcare and identify ways to improve outcomes.

Too often, the VFW hears stories of veterans who have been prescribed high doses of ineffective medications to treat their mental health conditions. Many of these medications, if incorrectly prescribed, have been known to render veterans incapable of interacting with their loved ones and even contemplate suicide. With the expanding evidence of the efficacy of non-pharmacotherapy modalities, such as complementary and alternative medicine (CAM) therapies, VA must ensure it affords veterans the opportunity to access effective mental health treatments that minimize adverse outcomes.

VA has made a concerted effort to change its mental healthcare providers' dependence on pharmacotherapy to treat mental health conditions and manage pain. In 2011, the Minneapolis VA Medical Center launched its Opioid Safety Initiative. Aimed at changing the prescribing habits of providers, the Opioid Safety Initiative educates providers on the use of opioids, serves as a tool to taper veterans off high-dose opioids, and offers veterans alternative—non-pharmacotherapy—modalities for pain management. Last month, VA deployed the Opioid Therapy Risk Report, a byproduct of the Opioid Safety Initiative, to enable providers to better track and manage their patients' high-dose prescriptions.

Timely and accessible mental healthcare is crucial to ensuring veterans have the opportunity to successfully integrate back into civilian life. With more than 1.4 million veterans receiving specialized VA mental health treatment each year, VA must ensure such services are safe and effective. VA has made progress in reducing its dependence on pharmacotherapy to treat mental health conditions and manage pain. However, more can be done to ensure veterans have access to CAM therapies that minimize side effects and improve outcomes.

H.R. 627, to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs:

The VFW is pleased to support this legislation, which would clarify the definition of homeless, thereby aligning it with the McKinney-Vento Act to include those displaced by domestic violence.

No veteran should ever be homeless, and expanding the definition of homeless to include veterans who are fleeing situations of domestic abuse is the right thing to do. This change would ensure veterans who have the courage to leave their abusive and sometimes life-threatening situations receive access to the benefits VA already provides to thousands of homeless veterans. The VFW believes this legislation will significantly improve the lives of those who become homeless as a result of difficult circumstances outside of their control, and help them begin a new chapter in their lives.

H.R. 1369, Veterans Access to Extended Care Act of 2015:

The Veterans Access to Extended Care Act of 2015 would strengthen VA's authority to enter into provider agreements with extended care facilities, while ensuring such facilities meet certain safety and quality standards. The VFW supports this legislation, but urges the Subcommittee to ensure it provides VA the authority it needs to properly administer all of its nursing home, assisted living, patient-directed and extended care authorities and programs.

VA has the authority to enter into provider agreements with extended care facilities to provide long-term care to veterans who need nursing home level services. However, a recent opinion by the Department of Justice found that VA provider agreements must comply with Federal Acquisition Regulations (FAR). Thus, VA has been unable to proceed with its plans to use its provider agreement authority to expand the extended care services it provides veterans.

The VFW has heard from many private sector extended care facilities that want to care for veterans, but do not have the staff to comply with the onerous compliance requirements under the FAR. As a result, veterans throughout the country received notice that they may be uprooted from the nursing homes they have called home for many years. For example, the VFW has received assistance requests from nearly a dozen family members of veterans in a nursing home in Lincoln, NE, that may no longer be able to provide services to veterans if its provider agreement with VA is not renewed. One of the veterans has rapidly progressing multiple sclerosis and needs comprehensive healthcare services. His family tells us he is satisfied with the "excellent care" he receives and was looking forward to calling the nursing facility "his home for the remainder of his days." This legislation would ensure this veteran and many like him are able to remain in the extended care facilities they call home, and authorize VA to provide the same opportunity for countless veterans.

H.R. 1575, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces:

This legislation would make retreat counseling services permanent for transitioning women veterans. The VFW supports this legislation and would like to offer suggestions to strengthen it, which we hope the Subcommittee will consider.

VA's counseling retreat program has served as an invaluable tool to help newly discharged women veterans seamlessly transition back into civilian life. The VFW supported the original program established by the Caregivers and Veterans Omnibus Health Services Act of 2010 and is happy to see this program continue.

Another successful program created by the Caregivers and Omnibus Health Services Act of 2010 is the childcare pilot program. This program has been well received by veterans at all four pilot sites and has also contributed to the success of the counseling retreat program. The VFW has heard from veterans who say they could not have completed their treatment programs if not for the services offered through VA's childcare pilot program.

When extending successful mental healthcare programs, such as the retreat counseling program for women veterans, the Subcommittee must ensure external barriers to access are removed to grant veterans the opportunity to receive the VA healthcare and

services they need. The VFW urges the Subcommittee to amend this legislation to extend and expand the childcare program to every VA medical center to ensure newly discharged women veterans with children are not precluded from obtaining the benefits and services they have earned and deserve.

H.R. 1769, Toxic Exposure Research Act of 2015:

The Toxic Exposure Research Act of 2015, which would establish an advisory board and a national center for research, would begin to address the multiple health issues faced by veterans and their descendants as a result of service-related toxic wounds. The VFW is pleased to offer its strong support for this legislation.

This nation has a long history of offering healthcare and compensation benefits to veterans who suffer traditional wounds on the battlefield. Veterans who suffer from toxic wounds, however, have traditionally faced a much more difficult road towards accessing the healthcare and benefits they have earned and deserve. The VFW believes that toxic wounds are wounds just the same and should be treated just as seriously as physical or mental wounds. Veterans who suffer from conditions as a result of service-related toxic exposure are equally deserving of VA healthcare and benefits.

Toxic wounds are different than other wounds, since toxic exposures have the potential to affect a veteran's descendants for several generations. For this reason, we strongly support the provision of this bill that would establish a national center for research to study the health effects service-related toxic wounds have on the descendants of individuals who were exposed to toxic substances during their military service.

Children of Vietnam veterans who were exposed to Agent Orange receive VA care and benefits for spina bifida, a debilitating health condition associated with a parent's exposure to dioxins found in Agent Orange. The VFW suspects that descendants of Vietnam veterans may suffer from additional health conditions that may be associated with exposure to Agent Orange. In addition, exposure to toxic substances is not limited to Vietnam veterans. The descendants of veterans who were exposed to toxic chemicals during the Gulf War, veterans of Iraq and Afghanistan exposed to open air burn pits, and service members exposed to contaminated water in Camp Lejeune, just to name a few, may all be suffering from diseases at a higher rate than the general population. This legislation is a step toward ensuring veterans' descendants can finally get the care and benefits they need.

Draft Legislation to Improve the Reproductive Treatment Provided to Certain Disabled Veterans:

This important legislation would expand VA's authority to furnish fertility treatments to veterans who have lost their ability to start a family as a direct result of their service-connected injuries. The VFW supports this legislation and would like to offer suggestions to strengthen it, which we hope the Subcommittee will consider.

Due to the widespread use of improvised explosive devices during the wars in Iraq and Afghanistan, both female and male service members have suffered from spinal cord, reproductive, and urinary tract injuries. Many of these veterans hope to one day start fami-

lies, but their injuries prevent them from conceiving. When these veterans seek fertility treatment from VA, they are told VA services are very limited. In fact, VA is prohibited from providing certain fertility treatments like In Vitro Fertilization. This legislation would expand VA's authority by aligning it with the Department of Defense's authority to furnish assisted reproductive treatments to severely injured service members.

However, service-connected infertility is not limited to those who have suffered reproductive organ and spinal cord injuries. Other injuries and illnesses such as Traumatic Brain Injuries and other mental health conditions are known to cause infertility. Such veterans deserve the same opportunity to start a family as their fellow veterans who have suffered injuries to their reproductive organs. For that reason, the VFW urges the Subcommittee to expand the eligibility for infertility treatment to severely wounded, ill, or injured veterans who have infertility conditions incurred or aggregated by their military service.

Additionally, veterans may have personal objections to assisted reproductive technologies such as In Vitro Fertilization and would like to pursue other options, such as adoption. However, VA is not currently authorized to help veterans cover the cost of adoption. The VFW believes that VA must have the authority to provide veterans the fertility treatment options that are best suited for their particular circumstances. For that reason, we urge the Subcommittee to grant VA more expansive fertility treatment authorities.

This legislation takes several steps toward ensuring veterans who have lost their ability to reproduce have the ability to start a family. It would authorize VA to cryopreserve a veteran's genetic material for up to three years. Starting a family is a life changing decision that takes time and should not be hastily made. The VFW strongly supports giving veterans the opportunity to delay such a decision. However, we urge the Subcommittee to expand the three year window. When totaled, a veteran's recovery, education and career advancement may cause them to wait years before they are physically and financially prepared to start a family. The VFW recommends that veterans be allowed to cryopreserve their genetic material for a minimum of 10 years. This will prevent veterans from feeling rushed into making family planning decisions before they are ready.

Additionally, many severely wounded, ill, and injured veterans have not lost the ability to produce gametes, but have lost the ability to conceive. The VFW strongly supports the provision that would authorize VA to furnish fertility treatments to non-veteran spouses.

Draft Legislation to Direct the Secretary of Veterans Affairs to submit an annual report on the Veterans Health Administration:

The VFW supports this legislation, which would require VA to report the utilization and efficiency of the healthcare it provides America's veterans. Such reports would enable Congress to conduct proper oversight of the department's Veterans Health Administration.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any federal grants in Fiscal Year 2014, nor has it received any federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

STATEMENT FOR THE RECORD OF THE

WOUNDED WARRIOR PROJECT

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

APRIL 23, 2015

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project® (WWP) to provide our views on pending health-related legislation today. Several of the measures under consideration directly relate to policy priorities of wounded warriors and their family members and we are encouraged to see their consideration. What follows are our comments on those bills.

H.R. 271 – The COVER Act

In 2014, WWP surveyed 21,120 wounded, ill, and injured veterans of this generation, who responded *en force*, and documented some of the challenges that they face. In this year's Annual Alumni Survey we found that 59.8% of survey respondents had been hospitalized as a result of their wounds or injuries,[1] with some 57.1% having suffered blast injuries and 14.7% bullet or shrapnel wounds.[2] Most of these warriors live with pain. In fact, two-thirds of the respondents said they live with moderate, severe, or very severe bodily pain.[3] Some 88.6% said their pain interferes with work; among them, 32.9% said pain interfered with work "extremely" or "quite a bit."[4]

Working with this generation of wounded, injured and ill veterans, we at WWP see daily the devastating impact of pain resulting from polytrauma and in-theater injury. Pain is the most frequent reason patients seek medical care in the United States.[5] In general, however, studies of VA patients show that the pain veterans experience is significantly worse than that of the general population and is thought to be associated with greater exposure to trauma and psychological stress.[6]

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[1] Franklin, et al.,2014 Wounded Warrior Project Survey: Report of Findings, 25 (July 30, 2014).
[2] Id., 24.
[3] Id., 46.
[4] Id., 46.
[5] Office of the Army Surgeon General, Pain Management Task Force Final Report, "Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families," E-1 (May 2010) . http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view. Accessed October 1, 2013.
[6] Id., 1.

The benefits of complementary alternative treatments are many. At WWP, we envision a generation of Wounded Warriors well-adjusted in body, receiving the care they need to maximize rehabilitation and live active and healthy lives. Through adaptive sports, health, nutrition, and recreational activities, WWP helps Wounded Warriors achieve independence and pursue an excellent quality of life. To realize these goals, our Physical Health & Wellness (PH&W) programs are designed to reduce stress, combat depression, and promote an overall healthy and active lifestyle by encouraging participation in fun, educational activities. Physical Health & Wellness has something to offer warriors in every stage of recovery. Our PH&W program goals are built upon four pillars:

1. Inclusive Sports - Inclusive sports allow warriors living with cognitive, emotional, or physical impairments to engage in local community-based activities to help them overcome both visible and invisible injuries. Participation in inclusive sports is a great tool for rehabbing and learning to thrive. Through sports and recreation, warriors can spark deep-rooted leadership skills and challenge buddies in some friendly competition.
2. Fitness - Making fitness a daily routine can change your life. Fitness activities such as run or walk events, dancing, crossfit, paddle boarding, cycling, and rock climbing are great for reaching personal goals such as weight management, physical endurance, speed, strength, and an overall healthier lifestyle.
3. Nutrition - Nutrition plays an important factor in well-being, especially when making new adjustments. By focusing on nutrition, Physical Health & Wellness educates warriors about the four major foods groups, teaches healthy food preparation techniques, and provides nutritional knowledge to promote healthy choices. Just because it's healthy doesn't mean it doesn't taste good. A strong focus on nutrition can have lasting benefits.
4. Wellness - Wellness focuses on educating warriors about healthy lifestyle behaviors and providing opportunities to participate in physical activities that embrace fun, leisure, and recreation. Active engagement in activities such as smoking cessation education, meditation, stress management, yoga, and scuba, can unite mind and body for an improved lifestyle.

The COVER Act (H.R. 271), would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

As we testified to in March of this year, access to mental health, and specifically providing alternatives to trauma-focused psychotherapy— including supportive group therapy and other evidence-based therapies— for veterans who wish to avoid revisiting trauma, is a priority for Wounded Warrior Project.

Combat stress and combat-related mental health conditions are highly prevalent among OEF/OIF/OND veterans and affect many who have sustained other serious injuries. Numerous studies have documented the profound consequences for warriors' overall health, well-being, and economic adjustment when chronic post-service mental health issues like post-traumatic stress disorder (PTSD) are left unaddressed. After more than a decade of combat operations marked by multiple deployments, the systems dedicated to providing mental health care to service members and veterans are still struggling to accomplish their missions.[1]

Wounded Warrior Project supports finding innovative ways to engage more wounded veterans in needed mental health care. In that regard, we have specifically supported approaches that would integrate complementary medicine into traditional practices as well as using complementary practices as a gateway to

evidence-based services to engage veterans who, for example, might otherwise be reluctant to seek or accept mental health treatment.

Improving the access, timeliness, and effectiveness of care for the invisible wounds of war (including PTSD, depression, and anxiety; TBI; substance use conditions; and chronic pain) through programmatic change—to include integrating complementary therapies—continued oversight, and legislation must be a priority for the Committees.

We also believe that providing alternatives to trauma-focused psychotherapy— including supportive group therapy and other evidence-based therapies—for veterans who wish to avoid revisiting trauma must also be pursued.

More can be done to help veterans transition into their communities and recover from the visible and invisible wounds of war. The COVER Act is a step in the right direction, and we encourage your support for the bill.

H.R. 1369 – The Veterans Access to Extended Care Act of 2015

Improvements in military medicine and technology have allowed disabled warriors from this generation to survive injuries that would have been deadly in previous conflicts, including severe traumatic brain injuries and injuries that affect many different systems of the body – also known as polytraumatic injuries. Many of these warriors will need care that calls on VA and their family for their entire life. Long-term injuries require long-term care above and beyond routine doctor's visits. Care and support provided by VA must be focused not only on function, but also on quality of life and ensuring that family members and caregivers are supported so they can continue to be there for their loved ones throughout the long journey to recovery.

Through Wounded Warrior Project's Independence Program, WWP helps warriors live life to the fullest, on their own terms. The Independence Program is designed for warriors who rely on their families or caregivers because of moderate to severe brain injury, spinal-cord injury, or other neurological conditions. In addition, the warrior's cognitive or physical challenges limit their opportunities to access resources and activities in their own community.

The Independence Program is a team effort, bringing together the warrior and his or her full support team while creating an individualized plan for each warrior — focusing on goals that provide a future with purpose at no cost to the warrior and his or her support team. It is designed as a comprehensive long-term partnership intended to adapt to the warrior's ever-changing needs. The Independence Program also provides support and training for involvement in meaningful activities, including social and recreational, wellness, volunteer work, education, and other living skills (including some activities and therapies specified in H.R. 271, the COVER Act).

Through partnerships with nursing home, adult day, and extended care service providers, Wounded Warrior Project helps meet an unmet need for these catastrophically injured veterans. The Veterans Access to Extended Care Act of 2015 (H.R. 1369), would modify the treatment of agreements entered into by the Secretary of Veterans Affairs to furnish nursing home care, adult day health care, or other extended care services. This modification would increase veterans' access to these community-based care providers and help meet the long-term needs of disabled veterans. We are supportive of this effort and recommend the committee's passage of the bill.

Draft legislation to improve reproductive treatment provided to certain disabled veterans

WWP thanks the Committee specifically for the opportunity to provide our thoughts regarding the fertility treatments provided by the Department of Veterans Affairs (VA). In our decade-long experience working daily with this generation of wounded warriors, we believe that there is a serious, unmet need to provide reproductive services and adoption assistance to assist in helping severely wounded, ill, or injured veterans who have service-incurred infertility conditions to have children.

Blasts from widespread use of improvised explosive devices in Iraq and Afghanistan, particularly in the case of warriors on foot patrols, have increasingly resulted not only in traumatic amputations of at least one leg, but also in pelvic, abdominal or urogenital wounds.[2] While not widely recognized, the number and severity of genitourinary injuries has increased over the course of the war, with more than 12% of all admissions in 2010 involving associated genitourinary injuries.[3] With that increase has come not only Department of Defense (DoD) acknowledgement of the impact of genitourinary injuries on warriors' psychological and reproductive health,[4] but the adoption of a policy authorizing and providing implementation guidance on assisted reproductive services for severely or seriously injured active duty service members.[5] DoD's policy, set forth in revisions to its TRICARE Operations Manual, applies to service members of either gender who have lost the natural ability to procreate as a result of neurological, anatomical, or physiological injury. The policy covers assistive reproductive technologies (including sperm and egg retrieval, artificial insemination, and in vitro fertilization) to help reduce the disabling effects of the service member's condition to permit procreation with the service member's spouse.[6]

For veterans, however, VA coverage is very limited in scope. The regulation describing the scope of VA's "medical benefits package" states explicitly that in vitro fertilization is excluded[7] and that "[c]are will be provided only…[as] needed *to promote, preserve, or restore the health* of the individual…(italics added)."[8] Consistent with that limiting language, the VA's benefits handbook advises women veterans with regard to health coverage that "…infertility evaluations and limited treatments are also available."[9]

The VA's policy of providing only "limited" services to veterans unable to procreate likely rests on at least two grounds. First, the VA has long construed its authority as limited to "treatment" of a disability, and as not extending to procedures that did not "treat" the underlying disability but were aimed at "overcoming" it. The VA's references to "limited treatment" likely also reflect a view that its statutory health care role is one of providing services to the veteran (and the veteran only), and thus does not extend to procedures or advanced technologies that involve not only the veteran, but a spouse or partner.

In a departure from longstanding policy, the VA stated last year that "[t]he provision of Assisted Reproductive Services (including any existing or future reproductive technology that involves the handling of eggs or sperm) is in keeping with VA's goal to restore the capabilities of Veterans with disabilities to the greatest extent possible and to improve the quality of Veterans' lives."[10] In its statement, VA also expressed support in principle for legislation authorizing VA to provide assistive reproductive services to help a severely wounded veteran with an infertility condition incurred in service and that veteran's spouse or partner have children. It conditioned that support, however, on "assurance of the additional resources that would be required."[11] While these advanced interventions require resources, cost should not be a barrier as it relates to this country's obligation to young warriors who sustained horrific battlefield injuries that impair their ability to father or bear children.

Families play a critical role in wounded veterans' reintegration, recovery, and rehabilitation. Military families have a unique culture, and learn to live with the shared sacrifices that come with military service.

Those who return from war with visible or invisible wounds that prevent them from having children can find the transition home even more challenging.

We are proud to support the Committee's work to expand fertility treatment for certain disabled veterans and their spouses. We would ask that the Committee also consider incorporating provisions from the Women Veterans and Families Health Services Act of 2015, S. 469, while this bill remains under consideration. The Women Veterans and Families Health Services Act, introduced by former Senate Veterans Affairs Committee Chairman, Senator Patty Murray, would also expand the treatment and care by the VA. Further, the bill would provide fertility treatment for spouses of severely wounded service members, provide adoption assistance for veteran families, and make permanent a VA veterans child care services pilot program.[12]

WWP urges the Committees to enact legislation that would enable couples who are unable to conceive because of the warrior's severe service-incurred injury or illness to receive fertility counseling and treatment, including assisted reproductive services.[13]

Conclusion

WWP envisions a future in which the most successful, well-adjusted generation of injured service members in our nation's history not only survives, but also thrives. This vision requires sustained public support, and relevant programs and services for veterans and their caregivers. Helping Wounded Warriors requires a lifetime of commitment. WWP commits to serving this population for their lifetime, and working with Congress and the Administration to realize this vision.

Thank you for the opportunity to comment on these important bills.

The mission of Wounded Warrior Project® (WWP) is to honor and empower Wounded Warriors. WWP's purpose is to raise awareness and to enlist the public's aid for the needs of injured service members, to help injured service men and women aid and assist each other, and to provide unique, direct programs and services to meet their needs. WWP is a national, nonpartisan organization headquartered in Jacksonville, Florida. To get involved and learn more, visit www.woundedwarriorproject.org.

[1] http://www.woundedwarriorproject.org/programs/policy-government-affairs/key-policy-priorities.aspx
[2] Dismounted Complex Injury Task Force, "Dismounted Complex Blast Injury: Report of the Army Dismounted Complex Injury Task Force," 1 (June 18, 2011) available at: http://www.armymedicine.army.mil/reports/DCBI%20Task%20Force%20Report%20%28Redacted%20Final%29.pdf.
[3] Id. at 16.
[4] Id.
[5] Asst. Secretary of Defense (Health Affairs) & Director of TRICARE Management Activity, Memorandum on Policy for Assisted Reproductive Services for the Benefit of Seriously or Seriously Ill/Injured (Category II or III) Active Duty Service Members (April 3, 2012) available at: http://www.veterans.senate.gov/upload/DOD_reproductive_letter.pdf.
[6] Dept. of Defense, TRICARE Operations Manual 6010.56-M, Chapter 17, Section 3, para. 2.6 (Sept. 19, 2012).
[7] 38 C.F.R. § 17(c)(2).
[8] 38 C.F.R. § 17(b) (Emphasis added).
[9] Dept.of Veterans Affairs, "Federal Benefits for Veterans, Dependents and Survivors" available at http://www.va.gov/opa/publications/benefits_book/benefits_chap01.asp
[10] *Health and Benefits Legislation Hearing Before the S. Comm. on Veterans Affairs*, 112th Cong. (2012).
[11] Id.
[12] Information about S.469 can be found at https://www.congress.gov/bill/114th-congress/senate-bill/469.
[13] To learn more about the how important fertility issues are to wounded service members, visit http://www.woundedwarriorproject.org/programs/policy-government-affairs/key-policy-priorities/objective-3-optimal-long-term-rehabilitative-care/initiative-4.aspx.